Health care for female sex workers: need, risk, access and provision

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Award date:
2006

Awarding institution:
University of Bath

HEALTH CARE FOR FEMALE SEX WORKERS:

NEED, RISK, ACCESS & PROVISION

Volume 1 of 1

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A thesis submitted for the degree of

Doctor of Philosophy

University of Bath

Department of Social and Policy Sciences

March 2006

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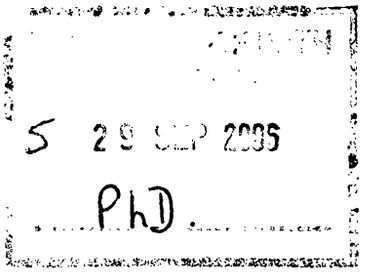
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ABSTRACT

Sex workers are not only acted upon by medical, moral and legal discourses due to the risk they present to their own health but also due to the perceived risk they pose to the health of others. The diverse settings and different ways in which sex can be sold, combined with previous life experiences contribute to the wide variation in need and risk. This thesis investigates the differential understandings of need, risk, access to and provision of health care between sex workers and health care service providers. Simultaneously it offers an explanation for the continuation of need when health care provision exists.

Four discursive themes directed the research: need, risk, access and provision. Data was obtained from semi-structured interviews with street and non-street sex workers and service providers. Discourse analysis was performed to ascertain the conditions, rules and authority under which statements in relation to the discursive themes are constructed. Thematic indexing enabled the analysis of the discursive themes within the empirical data, considering the inter-relationship with discursive constructs (i.e. stigma, safety, pollution, rights and power) identified within previous moral, medical and legal discourse.

Sex workers and service providers identified need and risk as problematic drug use, damaged mental health, STIs and violence, but categorise and prioritise differently. Complex constructions were identified, suggesting underlying influences that direct them. Contradictions and tensions exist within the differential construction of the discursive themes, made more problematic by the chaotic lifestyle of many sex workers. The differential understandings must be recognised or the sex worker will continue to be 'maintained' within the complex and interlinked relationships of prostitution, damaged mental health and problematic drug use, the latter two made worse by prostitution but not solely a result of prostituting.

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ACKNOWLEDGMENTS

Firstly and foremost I wish to thank the twenty one sex workers who gave me an insight into their lives, albeit briefly, by talking to me openly and honestly. The service providers who made time for me in their work schedule, among whom were the gatekeepers who enabled access to be gained to the sex workers.

I owe a debt of gratitude to my supervisors, initially Professor Pat Carlen and thereafter Dr Joanna Phoenix for her continual support and guidance. I am grateful to the ESRC (Award no. R00429934268) for their financial support.

Finally I thank my parents Thomas and Judith Leaney and Kevan Pennington who believed in me and encouraged me during the darkest times.

Previously Submitted Material

The research carried out in this PhD is supported by my MSc. research thesis (Leaney 2000). The MSc provided the equivalent of a pilot study of the service providers, clarifying terminology, the research field and the interview dynamic.

INTRODUCTION

> *"I was sexually abused and that when I was a kid, it just brings it all back...it makes you feel like shit about yourself the street, so I started cutting myself...and started bathing in bleach and disinfectant"* (Belinda – street sex worker).

At an individual level this study focuses on sex workers who are both similar and dissimilar to Belinda, specifically the way in which they and service providers construct the discursive themes of health need, risk to health, access to and provision of health care. The inter-related themes of need and risk are inherently ambiguous, redefined in legal, medical and moral discourses by continual processes of negotiation and reconstruction. Despite the discursive themes being difficult to measure, the use of discourse analysis within this study facilitates an understanding of how need and risk are described, who decides when someone is in need (e.g. at what point a problem becomes a need), or at risk, on what authority and why (e.g. for an individual's well-being or to protect public health). This in turn promotes the investigation of the rules and conditions by which sex workers use, receive, or are excluded from health care services and the way in which service providers provide and deliver health care services.

The study, where possible, generalises the individual constructions to provide group constructions to allow a differential comparison. Sex workers and service providers are different populations with disparate influences acting upon them and therefore hold differential constructions of need, risk, access and provision. To understand how sex workers and service providers construct these themes requires an awareness of their attitudes and behaviours (e.g. notions of responsible and irresponsible behaviour, life experiences, professional ideologies, personal bias), and where possible an interpretation of the influences that institutions/power groups, social relations and economic processes have on the construction. This understanding is important, as sex workers are governed by service providers in terms of health care provision and access, directed by the meanings attached to the discursive themes. It also enhances our understanding of the behaviour of the sex worker, their priorities and day-to-day decisions regarding need, risk and access to health care.

Historically the term 'prostitute' is heavily associated with concepts of stigma, constructions of deviance or immorality and blame, therefore in this study the term 'sex worker' is used, except where required for quotations or in a legal context. The term 'sex worker' still has negative connotations attached to it but not to the extent of the term 'prostitute'. Sex worker also implies an entire discourse, that is the discourse of prostitution as work, which is the way sex workers, described themselves (i.e. working women). Within this study sex workers are defined as women of eighteen years and above from any social class and ethnicity, who exchange some form of sexual service for direct (i.e. money) and/or indirect financial rewards (e.g. drugs, housing and/or consumer goods) and/or protection and/or the promise of love (Darrow 1984; Day and Ward 1990; Hoigard and Finstad 1992). Service providers interviewed were those primarily identified by sex workers, in statutory and voluntary projects or clinics providing health care within the biomedical or social model.

Due to the nature of their work sex workers are a stigmatised population. They are not only acted upon by service providers due to presenting a risk to their own health but also because they are identified as a risk to the health of others. Risk is perceived as not only starting with a sex workers' body but risk stops with her as well. For instance a sexually transmitted infection is assumed to originate from her body but little is talked about other possible origins of infection or the risk posed by an infected man having unprotected sex with a 'clean' sex worker. The diverse settings and different ways in which sex can be sold (e.g. from the street, parlour, escort agencies) combined with previous life experiences (e.g. physical and sexual abuse, damaged mental health) contribute to the wide variation in need and risk. Sex workers are also 'blamed' within moral discourse for undertaking risky behaviour, the consequence of which is further stigmatisation. This behaviour is rarely the result of informed, free choice, in some situations it is dictated by the instinct to survive (e.g. physical force, psychological trauma, financial need, drug addiction). It is the continuing intensity of sex workers need and risk, combined with the stigma of sex work and the inter-relationship of risk (i.e. posing a risk to others versus being at risk themselves) that make sex workers different from non-sex workers and the centre of this study.

I. THE THESIS AIM AND STUDY OBJECTIVES

This thesis has one main aim, which is supported by four objectives. The main aim is to identify and examine the differential understandings of health need and risk, access to and provision of health care in the context of prostitution between sex workers and health care service providers. To understand the lived realities of the need, risk, access and provision

(i.e. the discursive themes), the following objectives have been defined; to identify the *discursive themes,* how they are constructed by a *specific interviewee* and directed by underlying influences;

(i) need and risk, by the sex worker (see Chapter Four)

(ii) need and risk, by the service provider (see Chapter Five)

(iii) access and provision, by the sex worker (see Chapter Six)

(iv) provision and delivery, by the service (see Chapter Seven).

II. THE RESEARCH PERSPECTIVE

Reality is socially constructed, a dynamic process, produced by an individual acting on their interpretation and knowledge derived from their experiences and interactions. We all feel and express our health needs and are exposed to risks, and have subjective understandings of these concepts. The implication of this ontological position for this research is that differential constructions of need and risk exist for sex workers and service providers. Standards are created that evolve over time to allow us to define and know when individuals are in need and what their rights to provision are.

Thus we can be informed from discursive interactions what individuals perceive are their needs and risks. Determining the construction (i.e. attitudes and behaviours directed by rules under specific conditions affected by authority) that underlies these concepts is again possible from interaction and analysis. This epistemological position is prone to error as it is dependant upon the individual's ability to understand their perception of the construction of the concepts. This is also applicable to the researcher during analysis. This does not mean that we cannot know, but that it is subjective. We can also question and obtain an understanding of the construction foundations and influences, accepting the increase of researcher subjective misconceptions.

As the aim of this research is to uncover service providers' and sex workers' differential constructions of sex workers' need, risk, access and provision and the underlying influences, discourse analysis is the most applicable methodological approach as it enables the investigation of the underlying arguments and concepts of a statement. Normative

theories of need and risk support our understanding, providing indications of areas to probe or investigate during the discourse and inform the analysis of reasons directing the constructional influences. The approach is to obtain the data directly from sex workers as 'felt needs/risks' similar to the Bradshaw taxonomy, and from the service provider with a 'normative need/risk' approach.

III. OVERVIEW OF THE RESEARCH METHODS

To address the objectives the discursive constructs of pollution, rights, power, safety and stigma within moral, medical and legal discourses provided the theoretical framework for the study. To understand the interpretations and meanings attached to need, risk, access and provision, qualitative research methods in the form of questionnaires and semi-structured interviews were undertaken. These methods allow detailed investigation and priority to be applied to the accounts of the sex workers and service providers. The interviews were conducted with the research population who lived and worked in 'Old Port' during 2001. The population consisted of twenty one sex workers and ten service provider interviewees; three sex workers also took part in the questionnaires. The interviews explored potential and actual risks to health, type of past or present health need, type of health care services available and ease of use of these services.

Due to the vulnerability of sex workers working within a closed and hidden community, access was negotiated via gatekeepers. The sex workers interviewed had differing experiences of sex work, worked in any situation and sold any kind of sexual service. Non-probabilistic, purposive sampling was used to identify the service providers with the additional use of 'snowballing'. Due to the illegality of soliciting, the attached stigma and the sensitivity of the health needs and risks discussed, a good rapport and high level of trust during the interviews were essential. Confidentiality and anonymity were assured and informed consent was obtained. Analysis was undertaken in the form of Foucault discourse analysis organised using thematic indexing based on the theoretical framework obtained via the review of literature (Chapter One). Thematic indexing enabled the inter-relationship between the discursive themes (i.e. need, risk, access and provision) and the discursive constructs (i.e. stigma, safety, pollution, rights and power) to be analysed to determine the authority, conditions and the rules and the underlying influences (i.e. economic processes, social relations, institutions/power groups) that direct their construction. Differential comparison of the constructions was then undertaken. The primary aim was to obtain and understand the constructions as described above; Foucault discourse analysis provides an

insight into the influences of their construction of the discursive themes, but power/knowledge influences, and the construction of discourse (e.g. determining the discursive expressibility rules) are not principal considerations.

IV. APPLICATION OF THE STUDY

Much of the earlier research relating to need and risk has been descriptive and prescriptive focusing on sexual risk behaviour encompassing the extent and incidence of sexually transmitted infections, specifically HIV/AIDS and the disease's interdependence with (i) drug use, particularly crack cocaine, heroin and alcohol consumption (e.g. Gossop et al 1995, McKeganey and Barnard 1996), and (ii) the use and non-use of condoms (e.g. Day and Ward 1990). Presented in the chapters of this thesis is an analytical study focusing on the conditions, authority and rules under which statements in relation to sex worker need, risk, access and provision are constructed. The work described in the study does not measure the gap between need and provision. It illustrates the interplay between need and risk and how this is embedded within the social and occupational context of the sex workers' and service providers' lives. The study explains the complexity of social meanings and cultural relations that direct sex workers in their interpretation of situations and behaviours (e.g. not just selling sex and taking drugs but involving codes of conduct) and the contradictions in constructions that appear between sex workers and service providers. The study elaborates the contours of different understandings and meanings of need and risk via the discursive constructs of pollution, rights, power, safety and stigma. In doing so it offers a rich description and at times harrowing insight into how a vulnerable, stigmatised population makes sense of need, risk, access and provision to health care.

V. OUTLINE OF THE CHAPTERS

The following chapter, Chapter One, is a review of literature concerned with health need and risk, access to, and provision of, health care for sex workers, illustrating how constructions and understandings have changed. It identifies the discursive constructs of pollution, rights, power, safety and stigma within moral, medical and legal discourses that provides the theoretical framework for the analysis. Chapter Two provides the analytical framework. It discusses the perspective of Foucaultian discourse analysis (Foucault 1972), a theoretical perspective that promotes the exploration of meanings to ascertain the authority, conditions and rules under which statements in relation to sex workers' need, risk, access and provision are constructed. The second section of Chapter Two discusses

the inter-related theories of need and risk. The theoretical (Chapter One) and the analytical framework (Chapter Two) when combined form the discursive framework for the analysis of the empirical data.

An account of the research methods and the processes used is provided in Chapter Three. This chapter details how access was negotiated to the research population, it describes the environment (e.g. city of 'Old Port') and explains how the empirical data was gathered. A brief description is provided of each interviewee, and the ethical issues and research dilemmas encountered during the fieldwork with the resolutions are explained. The chapter concludes by detailing how thematic indexing was used to analyse the data obtained via the semi-structured interviews and how these were related to the discursive themes and constructs.

Chapters Four and Five document the results from the analysis of the sex workers' and service providers' interviews respectively, which provide an understanding, of how each population constructs need and risk, and the relationship to the discursive constructs. Chapters Six and Seven perform a similar purpose for the discursive themes of access and provision also taking into account the respective constructions of need and risk. The study concludes with Chapter Eight within which the main findings are summarised and a differential comparison made of the constructions. Additionally an explanation is offered for the continuation of need when health care provision exists.

Chapter 1

CONSTRUCTING THE THEORETICAL FRAMEWORK: DISCOURSES & DISCURSIVE CONSTRUCTS

This chapter will provide a historical overview of literature concerned with sex worker health issues, identifying the influential discourses and discursive constructs in relation to health need, and risk, access to, and provision of health care for sex workers. It will be shown that the discursive constructs of pollution, rights, power, safety and stigma are prominent within moral, medical and legal discourses relating to prostitution. These constructs and discourses will provide the foundation for the thesis.

Prostitution has a long history, recorded in medical, moral and legal discourses. Within medical discourse the difference between female sex workers and non-sex worker women is identified as being located in the body. Sex workers' bodies were and are still perceived to be sexually unclean, a carrier of infection, symbolically associated with venereal disease. Illegal drug abuse has added to the health need and risk of sex workers extending the discursive constructs of infection control and stigma, whereas damaged mental health limits the power and rights of the sex worker and therefore puts her safety at risk. Due to the reality of health need and risk of harm to the sex worker, Barnard (1993) believes prostitution needs to be classified in occupational health terms and not only as a public nuisance or as a risk to public sexual health. Despite Barnard's concern for the sex worker the dominant biomedical constructions remain pollution: the sex worker as 'polluter of sexual health', and safety: of the general population's sexual health.

In moral discourse the perceived difference between 'voluntary' sex work and non-sex worker women is located within notions of social and moral unacceptability, specifically the distinction between normal and deviant behaviour. Kantola and Squires (2004, p.78) write *"[T]he moral order discourse draws on a...complex synthesis of international human rights rhetoric, religious orthodoxies and a feminist perspective on sexual domination"*. The sex worker is seen as a socially harmful evil (Weeks 1989), not only a sinful misfit, but a sexual slave and a victim of pimps. In this latter scenario the sex worker not only degrades herself by undertaking sexually immoral behaviour but all women, in turn undermining the family. Hubbard (1999, p.164) confirms this view of the sex worker "...polluting the moral order of

the community". Sex workers are perceived to hold different moral, sexual and religious values. Hubbard and Saunders (2003, p.75) write *"...the female prostitute constitutes a central figure in the social imagination, playing an important symbolic role in the definition of moral standards".* Public nuisance discourses also contain inferences to the sex worker as an offence to public morality to be controlled and contained. Sex work is believed to bring dangerous and threatening social phenomena (e.g. drugs, crime) into local communities, breaking down cohesiveness. Non-sex worker women and children living in these communities are described to be the innocent victims of the immoral behaviour of sex workers. In 1994, South Asian Muslim residents of Balsall Heath, Birmingham began a direct community protest picketing local sex workers to protect respectable female sexuality and children, places of worship, and rid the area of its reputation as an 'immoral space'. *"The pickets justified such actions by arguing that street prostitutes represented the embodiment of vulgar and conspicuous sex, with a language of moral outrage used to stress that prostitution was assaulting public decency"* (Hubbard and Saunders 2003, p.81). In contrast to the immorality of the 'voluntary' sex worker, the development of policy in relation to trafficked women has been constructed within a moral order discourse focusing on the innocent victim of sexual exploitation requiring human rights protection. Medical and moral discourses persist in the construction of the sex worker as a 'polluter of others'.

In a court of law a 'common prostitute' is subject to a legal discourse, which stigmatises, and promotes exclusion. Women are excluded from the general population due to the label of 'common prostitute' and a range of offences that relate to with whom she lives and works with. These are aspects of legal discourse, which limit the power of a sex worker to exercise individual rights. Nonetheless, sex workers believe they are performing a social role, for instance providing a service, which keeps the family together, and are providing a sexual outlet for lonely men, preventing at the extreme the act of rape of non-sex worker women (Day and Ward 1990). This double standard adds a further dimension to the discursive construct of safety, that of the sex worker protecting the general population. Despite legal sanctions and moral attitudes prostitution continues.

I. DIMENSIONS OF POLLUTION

The construct of pollution within medical and moral discourses has historically and in more recent times implied that sex workers contaminate and defile the general population. The sex worker is identified as though she is a 'polluter of others' although infrequently the sex worker is also identified as though she is 'polluted by others'. This directs the way in which

sex workers are acted upon and the choices sex workers make. This section of the thesis describes specific forms of pollution: infection control, moral contamination, victims of pollution, and legislation, using the characteristics of pollution within medical discourse (e.g. sexual infection, drug abuse and damaged mental health) and moral discourse (e.g. Christian concept of the family and wife involving sexual relationships, responsibility for own health and to others).

1. CONTROL OF INFECTION

(i) Syphilis and Gonorrhoea

Historically sex workers have been associated with, and blamed for, the occurrence and spread of syphilis and gonorrhoea. During the eighteenth century male and female bodies were seen to biologically diverge, the vagina and secretions were no longer seen as the equivalent of the male penis but as diseased and not the norm. In the early nineteenth century, with the increase in venereal disease, sex workers were targeted on both moral and public health grounds. A steady increase in venereal disease among military returns focused the concern of Victorian Britain on prostitution. By 1864 one in every three reported illnesses in the army were venereal in origin, *"...admissions into hospital for gonorrhoea and syphilis reached 290.7 per 1000 of total troop strength"* (Walkowitz 1980, p.49). By the late 1800's physicians believed it was possible to identify possible carriers of syphilis and other venereal disease by the way certain women looked. Abnormal sexual functions (e.g. infertility, menstrual problems) were also used to distinguish sex workers from non-sex worker women. Therefore, it was believed that women who solicited were easily identified for sexual regulation (Spongberg 1997). Women with a capacity to carry venereal disease were also thought to have an aptitude for prostitution. Men were classified as victims and women, especially if promiscuous, were the source of disease (Spongberg 1997). Sex workers were abnormal, indulging in not just sexual excess but alcohol and other addictions. The gulf increased between 'normal' and 'abnormal' women. Sex workers were morally and physically blamed for the transmission of venereal disease.

Corbin (1990) writes that sex workers were symbolically associated with syphilis. In the mid nineteenth century the prolonged and far-reaching consequences of secondary and tertiary syphilis on internal organs with progressive paralysis had been established. The theory of hereditary syphilis developed from the 1860s *"...hung* [like] *a sword of Damocles over the descendents of syphilitics as well as over the nation's future"* (Hill 1995, p.289). Both the seriousness and prevalence of gonorrhoea was not realised until the 1870s, beforehand

women were believed to be asymptomatic as no or few outward signs of the disease were observed. However, it was realised that the lack of symptoms did not mean that a woman was free from disease. Thus, new medical knowledge resulted in sex workers being seen as an even greater danger to public health. Despite advances in *"...aetiology, pathogenesis and diagnosis of venereal disease...therapeutic measures were lengthy, unpleasant or painful and had considerable side effects but little success"* (Hill 1995, p.289). It was not until the advent of penicillin (1928) that the two diseases lost some of their terrifying character.

The construction of sex workers as 'polluters' and male clients as victims persists. As recently as the early to mid 1970's arrested sex workers in America were quarantined for venereal disease. In San Francisco COYOTE (Call Off Your Tired Ethics) was successful in lifting the three day mandatory quarantine imposed by the police force (Jenness 1990). More recently, and to counter uninformed speculation (there is no official data on the number of sex workers with gonorrhoea and syphilis in the UK) various research projects have produced the following figures. In Sheffield between 1986-87 28% of 68 prostitutes had at least one episode of gonorrhoea (Woolley et al 1988) and in 1989-91 44% of 280 sex workers interviewed in London reported a past history of gonorrhoea (Ward et al 1993).

Sex workers have a high lifetime risk of gonorrhoea. Ward et al (1993, p.356) associated the risk of contracting gonorrhoea with a young age, increasing numbers of non-paying clients rather than with the numbers of paying clients, reports of condom failure or length of time prostituting. In Sydney, Australia, gonorrhoea occurred eight times more in sex workers than non-sex worker women and chlamydia and pelvic inflammatory disease twice as often (Harcourt and Philpot 1990). Vulvo-vaginitis, genital herpes, non-gonococcal genital infection and genital warts are also common sexually transmitted conditions in sex workers. Many of these conditions, if untreated, result in long-term health needs such as infertility. Gonorrhoea and syphilis *"...have been identified as possible co-factors for HIV infection and the subsequent development of AIDS"* (Harcourt and Philpot 1990, p.146), which further adds to the construct of pollution, within medical and moral discourses.

(ii) HIV/AIDS

The first recorded individual in the United States of America to be infected with HIV was a female sex worker. The first recorded death in the USSR due to AIDS was also a female sex worker (Plant 1990). Sex workers have been blamed for the transmission of HIV due to

the large numbers of sexual partners. However, these reports distort the true picture of prostitution and HIV/AIDS within medical and moral discourses.

Accepting money for some form of sexual service does not put the sex worker at risk of HIV infection but "[i]*t is how people engage in specific high risk activities that can put them at risk*" (Morgan Thomas 1992, p.71). The risk of sexual infection attached to the sexual service is reduced by the use of condoms. Nonetheless, previous research has indicated that condom use varies between different types of prostitution. For instance in Liverpool in 1986 female street sex workers reported practising unsafe sex at the request of the client due to financial need and poor knowledge concerning HIV/AIDS (Matthews 1990). Unsafe sex was practiced due to the complexity of negotiating safer sex and the need for the sex worker to fund an increasing drug habit (so agreeing to clients sexual demands). "*I'll do anything to make my money when I'm turkeying...you have to take that risk when you need the money*" (A female crack using sex worker in Matthews 1990, p.64). High levels of risk behaviour were identified by Kinnell (1989) and initially Harcourt and Philpot (1990) among sex workers working in saunas and massage parlours. Sex workers working on the streets on the other hand could not financially afford to become ill as a result of not using condoms and once ill showed a reluctance to seek medical help (Harcourt and Philpot 1990). However, Woolley et al (1988) identified higher risk behaviour among sex workers working from the streets. Morgan Thomas (1990) recorded that 8 out of 99 female sex workers rarely or never asked their clients to use condoms, 31 out of 103 sex workers charged more money for unprotected sex and 40 reported occasionally having unprotected sex with clients (ibid., page 94). In the same study the female sex workers interviewed reported using condoms for approximately 56% of clients for vaginal intercourse. However, in estimating condom use with clients in the week preceding the interviews, condoms were used in 87% of contacts for vaginal and 100% of contacts for anal intercourse (ibid., page 94).

Awareness in relation to HIV/AIDS had increased the use of condoms in client contact for 66% of the sex workers interviewed by Morgan Thomas (1990, p.95). However, over a decade later fifteen (37.5%) sex workers in Sharpe's (1998) study reported being offered more money for unprotected sex, a phenomenon reported elsewhere (McKeganey et al 1990). During 1988-1989 Morgan Thomas et al (1990) interviewed 209 clients of sex workers (206 male clients, 3 female clients) of which 172 male clients reported having contact with only female sex workers. One hundred and twenty one clients reported using

condoms, one in eight of the clients of female sex workers reported not using a condom and almost one third of the group reported paying more for unprotected sex. Twenty six clients reported intravenous drug use, sixteen of whom had shared needles and syringes after 1980. Of fifty four clients tested for HIV, seven were seropositive all of whom had used intravenous drugs (ibid., p.525). Despite the risk client behaviour clearly poses to the health of the sex worker, Sharpe (1998) found that sex workers did not associate HIV/AIDS as a risk from the clients but the danger was identified to be from less 'careful' sex workers on the street.

Risk behaviour in relation to HIV/AIDS has been identified as intravenous drug use (Johnson 1988, Day et al 1988) and the practice of unsafe sex, primarily with non-paying partners. Day and Ward (1990, pp.68-69) found that 82% of the sex workers that they interviewed reported not using a condom with private partners. The practice of unsafe sex occurs despite the knowledge that some non-paying partners have unprotected sex with other women and are also intravenous drug users. The use of a condom at work is to protect against sexually transmitted infections and to enable the sex worker to make a distinction between sex for money (at work) and sex for love (at home). The condom represents both an emotional and physical barrier. Nonetheless, sometimes the line between private sex and paid sex becomes blurred, especially in relation to 'regular' clients who provide an assured income (Venema and Visser 1990). The undertaking of high risk sexual activities outside of work within private relationships illustrates the complex nature of the prioritisation and negotiation of risk.

Ward et al (1993) found that out of the 1.7% in 1986-8 and 0.9% in 1989-91 of the 280 women studied, all cases of HIV/AIDS correlated with injecting drugs using unsterile needles and the practice of unsafe sex. Morgan Thomas (1990, pp.99-100) reported that 28 out of a total of 101 sex workers used intravenous drugs at the time of the study, of these, 12 sex workers shared injecting apparatus on an average of 7.5 times a month with approximately 6.5 different individuals. Sharing of needles and syringes among sex workers was also reported by McKeganey et al (1990), being described as part of the social relationships connected with both prostitution and drug taking, involving irrational and emotive attitudes. Practices in relation to sharing drug equipment had changed slightly in 1992. Only a few sex workers interviewed by McKeganey et al (1992) reported sharing needles, due to sterile injecting material available via outreach and needle exchange schemes in Glasgow.

It is important to note that incidence of infection varies widely between different groups of sex workers, within different regions and different countries (McKeganey et al 1990). For instance between 1986-87 no sex workers were infected in Sheffield (Morgan Thomas et al 1990), whereas in 1988 14% of sex workers in Edinburgh were reported to have the virus. However this includes male sex workers and reflects the high incidence of injecting drug users, 60% of 208 street working sex workers contacted were injecting drug users (McKeganey and Barnard 1992). In 1994 the incidence of HIV among drug injecting sex workers in Glasgow was below 5% (Goldberg et al 1994). These variations are thought to be due to the *"...availability of complete and accurate global AIDS statistics"* (McKeganey and Barnard 1992, p.2) and different behaviour that increases the risk of infection between and within populations. The latter point is illustrated by the increased use of crack cocaine by street sex workers in some UK cities and the corresponding increased incidence of sexual infection. Notably in Sub-Saharan Africa prostitution plays a pivotal role in the transmission of HIV infection with no correlation with intravenous drug use, whereas in the UK as the following section will explain there is a high correlation between the activity of commercial sex and the use of drugs (Plant 1990; Hoigard and Finstad 1992).

(iii) Drugs

Substance abuse is seen to defile a woman's reason for being, that of reproduction (Ettorre 1992). A sex worker is characterised as *"...a woman who is doubly polluted because she consumes drugs on the illegal market and 'produces' illicit sex consumed by male clients"* (ibid., p.78). Brewis and Linstead (2000a, p.84) state "[d]*rug use appears to play a paradoxical role in prostitution".* Sex workers work in extremely stressful settings, in an *"...atmosphere of violence, constant threats and frequent experience of physical abuse"* (Estebanez Estebanez 1990, p.190). Work is unpredictable with frequent changes in rewards, autonomy and locations (Scambler et al 1990).

There has been much debate on the causal link between drug use and sex work, and if there is a link, the order in which they occur (Cusick 1998). It is difficult to differentiate between whether women start working on the streets to support their habit or if they start taking drugs once on the streets (Plant 1990). Goldstein (1979) reported there was little evidence to prove that involvement in prostitution resulted in drug use or drug use resulted in prostitution. On the other hand, Brewis and Linstead (2000a, p.86) believe *"...most injecting prostitutes take to sex work as a means of funding an already established habit either their own or that of their partners".* Dalla (2000) reported 53% of her forty-three

interviewees used recreational drugs before they started working from the street, and 76% claimed to become regular users after starting. Once using, the pattern is of progressive drug use either due to an increase in income or by association with other drug using sex workers, after which *'[r]eticence to commence prostitution and aversion to continue with it, was expressed exclusively by drug-addicted street-working prostitutes"* (Cusick 1998).

Illegal drug use is covert, stigmatised and as with the numbers of women involved in prostitution is a largely hidden population. A multitude of different drugs are used by sex workers to achieve varied effects (e.g. to enhance sociability, decrease fatigue, increase confidence). Drugs act as disinhibitors, producing a coping mechanism that enables the sex worker to continue to work, masking the negative feelings they have concerning their work. Cannabis is for mainly recreational use, whereas amphetamines, cocaine and heroin combined with Temezepam, Valium, Distalgesic and solvent abuse are used for working. The highest level of intravenous drug use is found among sex workers working on the streets (Harcourt and Philpot 1990). Of the sex workers taking heroin in Sharpe's (1998, p.94) study an average of £100 per day was spent on drugs. On the other hand *'[i]ndoor prostitution is seldom associated with addictive or routine drug use"* (Cusick 1998, p.128), although in the last ten years there has been growing acceptance of recreational drug use. A growing concern is the increase incidence of the use of crack cocaine by street sex workers (Green et al 1999). *"The extreme danger of the drug...is those addicted to crack...consume the drug during periodic binges in which the pursuit and use of crack outweigh other concerns"* (Fullilove et al 1992, p.276). Crack cocaine has been linked to decreasing prices at street level sex work (Faugier and Sargeant 1997)

Alcohol is in a different category; it is a legal drug obtained in pubs, bars and hotels, all of which are popular places for sex workers to meet clients. Alcohol is associated with specific social and cultural behaviours, increasing sexual freedom and making contact with clients easier for the sex worker. Sex workers working on the streets spend less time socialising as they are paid for the actual sexual service and not the amount of time spent with a client (Sharpe 1998). In 1988 the mean alcohol consumption was 48.1 units per week, and 20% of the 103 sex workers interviewed by Morgan Thomas (1990) on occasions accepted alcohol as payment for some form of sex.

Prostitution is seen by the sex worker with a drug addiction, specifically heroin, as the quickest, 'easiest' and the least deviant behaviour to earn money, attracting less serious

penalties when compared with, for example, shoplifting. Working on the streets provides the freedom to work the hours needed, when capable, to pay for the individual addiction without paying a percentage of the money earned to a parlour owner, although a boyfriend, husband or pimp may take some if not all of the money. Bloor et al (1991, p.1482) recorded 172 out of an estimated contactable 304 street sex workers in Glasgow during 1989-1990 (i.e. six months) were intravenous drug users. In 1991, 71% of 206 street sex workers were intravenous drug users (McKeganey et al 1992). This is a much greater incidence than reported in other towns/cities: 15% in Birmingham (Kinnell 1989), and between 8% to 14% in London (Day et al 1988).

Problematic drug use and alcohol consumption may decrease judgement (e.g. of the type of client) and the ability to make decisions relating to the undertaking of unsafe sex. It is also not only the use of intravenous drugs that places the sex worker at risk of ill health, but supporting a partner's drug habit is linked to working longer hours and more frequently than non drug using sex workers, increasing the time spent in potentially dangerous situations (McKeganey et al 1990). A partner using intravenous drugs unsafely puts the sex worker at risk of acquiring HIV/AIDS and Hepatitis especially as discussed previously due to the low use of condoms with non-paying partners. However, a clear distinction needs to be made between sex workers who use intravenous drugs and those who do not, as this affects the incidence and risk of infection due to the ability or inability to follow risk reduction rules. The sex workers themselves make distinctions between those who inject drugs and those who do not, although in reality boundaries are not 'clear cut' (McKeganey et al 1990).

The belief by the population in general and some health care providers specifically that sex workers firstly undertake high risk activities (e.g. selling sex, use of intravenous drugs) and secondly undertake these activities without taking the necessary precautions (e.g. use of condoms, non sharing of needles) further adds to the construct of 'pollution' within medical and moral discourses.

2. SEX WORKERS AS A MORAL 'POLLUTANT'

The first recording of prostitution was approximately 2000 BC when it was part of religious ritual and highly respected. Open sexuality was encouraged in Ancient Greece and large revenues were gained from prostitution with registered brothels co-existing with unregistered street work. When the Roman Empire fell *"...the church's moral view of sexuality became more repressive"* and *"...attempts by both the Catholic and Protestant*

Churches to eradicate all sexual trade..." (Carr 1995, p.202) continued throughout the Renaissance and Reformation. In Britain during the 16th and 17th centuries, brothels although illegal were tolerated, but by the early 19th century *"...regulation and control of brothels as a means of social control had been reintroduced into Europe"* (Carr 1995, p. 203). Therefore, the need to regulate and repress prostitution has historically been driven not only by fear of physical contamination, but also by the belief that prostitution is intrinsically immoral. Religions often justify the perception of sex workers as not only physically 'polluted' but morally 'polluted' and 'a pollutant'. Until 2004 responses towards sex workers involved a double standard of morality as legislation penalised women but not men for the same act. Morality *"...informs the system of sanctions around soliciting and which punishes people not so much on the basis of their actions, but more directly on the basis of their status and sexual orientation"* (Matthews 1986, p.196). Mill (1859, cited by Oliveira 2004) believed that immoral behaviour (i.e. behaviour which opposed the beliefs of the majority) between willing individuals in private was not the concern of the law unless the behaviour was harmful to others.

Sex workers are perceived to deviate from the stereotypical behaviour of 'normal' and 'good' women (Dobash and Dobash 1979). Prostitution is perceived as betraying female virtue, commercialising through the act of exchanging sex for some form of payment, the sacred female body. The selling of sex involves a high degree of sexual promiscuity, which is believed, to be unnatural (Sharpe 1998). Sex workers are seen to make themselves overtly available to sell sex and dress for sex, contradicting normative expectations of a submissive female. The perceived 'unchastity' of sex workers continues the mythologies surrounding sex work enabling justification of the oppression and abuse of sex workers by men, with limited fear of legal reprisal. Justification for violence against sex workers is further ingrained by the Madonna-Whore continuum (Heidensohn 1985) whereby the Madonna refuses but the Whore encourages male sexual advances. Sexual reputation combined with the use of drugs and alcohol further damages the social respectability, sexual purity and morality of the sex worker.

HIV/AIDS is seen as a suitable punishment for deviant, immoral behaviour. The advent of HIV/AIDS further enabled moral judgement to be passed on the sex workers' 'choice' to solicit. The disease is used as a negative icon to scapegoat, criminalise and victimise sex workers. The lack of rights (e.g. to work without fear of violence, to seek health care without being stigmatised) afforded to sex workers and the prejudice directed towards them is

illustrated by the perceived negative reactions that McKeganey and Barnard (1996) believe their suggestion that alternative ways for HIV positive sex workers to support themselves need to be found. Right wing moralists may identify this as rewarding immoral people for deviant behaviour and becoming HIV positive.

The concept of the sex worker as a 'moral pollutant' is intertwined with specific forms of the sex worker as a 'physical pollutant', infecting and thus victimising 'others'. The following section will discuss: (i) the military/general population: (ii) the 'polluted' family (iii) 'polluted children' (iv) 'polluted' womanhood, (v) and in doing so it explores historical and recent issues.

3. SEX WORKERS AS A PHYSICAL 'POLLUTANT'

"All diseases have social, ethical and political dimensions" (Weeks 1989, p.1). Different meanings are attached to illness and there is a long tradition of connecting disease with moral issues. In the nineteenth century syphilis was described as the 'social disease', while sex workers were known as the 'social evil' (Weeks 1988). The terms thereafter became interchangeable. Sex workers are discussed in terms of the construct of pollution due to the notion that they contaminate others. They have *"...long been perceived as a public health threat"* (Morgan Thomas 1992, p.75). The advent of AIDS and the realisation that it could be transmitted heterosexually continued the belief that commercial sex is immoral, unclean and linked with the spread of diseases whose victims are numerous and diverse (Richardson 1987).

(i) The Military/General Population

Walkowitz (1980) argues that though in the Victorian era physical illness of sex workers was a major concern, the emphasis was on the risk not only to the military but the general population. This is the era when prostitution was classified as a social problem that continues to this day. Both syphilis and gonorrhoea were identified as needing preventive measures and sanitary supervision, which were specially aimed at the 'common prostitute'. Sex workers were targeted as it was believed that promiscuous sexual contact with diseased sex workers spread syphilis. Venereal disease was medically defined as being spread by women, specifically sex workers, with no attempt made to hospitalise or treat men. Sex workers were seen to gain financially from the sexual act whereas for men sex was a natural impulse that was difficult to control. The Contagious Diseases Acts (1864, 1866 and 1869 cited in Walkowitz 1980) reinforced the sex workers' body as infectious.

Sex workers registered under the Acts had fortnightly examinations, and lock hospitals (a hospital containing venereal wards) were established where women could be placed via the police and judiciary for up to nine months. The Acts enabled the distinction to be made between all females being infectious to only women identified as sex workers being diseased and transmitting disease to men (Spongberg 1997).

The Contagious Disease Acts were suspended in 1883 and repealed in 1886, amid mounting public protest. However, Amendment 40d of the 1918 DORA (Defence of the Realm Act) legally reintroduced the association between prostitution, syphilis and degeneration, specifically mental degeneration. Legislation was brought in to enable the policing of sex workers' diseased bodies. The 1918 Act made it illegal for sex workers who knew they were infected with venereal disease to solicit or invite or have sexual intercourse with any member of the armed forces. If a sex worker was thought to be breaking the law, she could be contained for a minimum of a week for medical examination to ascertain the presence of venereal disease and imprisoned for six months if found guilty (Spongberg 1997). Despite public protest the Act was not repealed until the end of the First World War.

Military leaders have continued to be concerned about the perceived risk that sex workers create for the transmission of sexually transmitted disease among their troops. Males serving in the armed forces abroad are likely to be unmarried and away from family and friends, increasing a higher level of promiscuity. Up to half of the soldiers serving in the Boer War (1899-1902) suffered from venereal disease and up to 20% in some military outfits in the Second World War. The concern of the perceived risk that sex workers create for national defence is aptly illustrated by health education propaganda released during the Second World War "[a] *German bullet is cleaner than a whore"* (Morgan Thomas 1992, p.75). More recently, most service men in Singapore receiving treatment for a sexually transmitted infection reported sex workers as the source of the infection (Bradbeer et al 1988).

With the 'arrival' of AIDS the risk of infection was perceived to be isolated into deviant communities of 'others,' including sex workers. As with venereal disease, sex workers were categorised as the cause of HIV and not as the victims. Nonetheless, it soon became apparent that HIV was not group 'specific', but with 'risky' sexual behaviour boundaries between groups (i.e. wives, mothers, sex workers, intravenous drug users) dissolved, and the virus threatened the 'self' (Juhasz 1993). However, clients far outnumber the sex

worker and Kruhse-Mountburton (1992, cited by O'Neill 1997) identifies the behaviour and attitudes of clients as the determining factor in the effect of sexually transmitted infection on the community. As already discussed in the thesis, a small but important minority will pay more for high risk unprotected sex (Morgan Thomas et al 1990; McKeganey et al 1990).

(ii) The 'Polluted' Family

In practising prostitution the sex worker is seen to 'pollute' the *"...family and the health of men by wantonly providing the illegitimate social outlet for natural forces..."* (Frankenberg 1989, p.35). The perceived threat to the family in the form of venereal disease became an issue of grave social significance for late Victorians. Heightened morality resulted in individuals being responsible for protecting not only themselves but their families from venereal disease (Horton and Aggleton 1989). Congenital syphilis became the 'disease of the innocent' in relation to children. Women, the mothers and teachers of domestic values, became innocent sufferers if perceived as morally blameless.

The construction of HIV/AIDS within medical and moral discourses continues concern about 'pollution' of the unborn child and the failure of the woman as a mother. If a woman is aware of being seropositive before becoming pregnant and does not want a termination, a number of interventions (e.g. treatment by antiretroviral drugs during the pregnancy and labour, use of caesarean section and avoidance of breast feeding) can be carried out to reduce the risk of transmission of the virus to the child. Due to the advances in the prevention of mother to child transmission, women are offered and recommended to have an HIV test when undergoing other antenatal screening. Attention and fear in the era of HIV/AIDS has re-focused on sex workers infecting 'normal' heterosexual men and therefore their 'normal' partners and their offspring. Thus discourse has reformed again. Both moral and medical discourse construct the women of the general population versus those at risk (Patton 1993), with clients holding no responsibility for their actions but *"...merely victims of the evil and predatory sex workers"* (Morgan Thomas 1992, p.72).

The risk that the sex worker poses to the family is not solely seen in relation to the actual sexual act but in terms of the by-product of that act. Careless disposal of used condoms and needles in areas where children play is seen to put children at risk from infection and in turn threatens the health of the family (Europap 1999).

(iii) 'Polluted' Children

The exact number of children involved in prostitution is hard to define and controversial. It is a hidden population, *"[I]t is thought that up to 5000 are involved at any one time"* (Melrose et al 1999, p.5) and the number is believed to be growing. There is a need conceptually to distinguish between adult and child prostitution, as when young people are involved the concern is more one of exploitation and sexual abuse by adults than a concern about prostitution per se. The Children Act (1989) defines a child as under the age of 18. However, law relating to prostitution does not distinguish between adults and children. Therefore, young women under 16 who, according to the law, cannot consent to sexual intercourse can be charged and convicted for soliciting to sell sex from the age of thirteen.

In May 2000 in an attempt to mitigate the arrest of children involved in prostitution, the Home Office with the Department of Health, Department for Education and Employment and The National Assembly for Wales published 'Safeguarding Children Involved in Prostitution'. This publication made no amendments to existing legislation, but was a guide for Area Child Protection Committees to use with *"...child protection rules, procedures and treatment"* (Phoenix 2002, p.359). The aim of this publication was to raise awareness and to ensure a welfarist inter-agency approach that treats children primarily as victims of abuse (i.e. a child protection issue), safeguarding and promoting the welfare of children, to investigate and prosecute those exploiting children. Nonetheless, in defining children as victims, it ignores the multifaceted and limiting social and economic conditions under which children 'rationally' become involved in prostitution, *"...the 'real' problem is the presence of those who entice, threaten or intimidate young people into prostitution"* (Phoenix 2002, p.359). The guidance does not discount the criminal justice system completely. Those assessed to continually and voluntarily return to prostitution despite the intervention of welfare agencies are referred to the Youth Courts within which disposals under the Crime and Disorder Act 1998 (e.g. tagging, curfews) are used, thus defining children involved in prostitution as blameless and deserving of protection opposed to those who are undeserving of protection and deserving of punishment. The issues of child prostitution and 'polluted children' were made more complex by the introduction of the Sexual Offences Act 2003. It is now illegal to cause or incite, arrange or facilitate child prostitution. As Phoenix (Phoenix and Oerton 2005, p.90) argues *"[t]he effect of these new provisions...is to criminalize **any** adult who might have some type of involvement in a young person's experience of prostitution".*

As with adults engaged in prostitution, the problems of child sex workers are multi-faceted. Therefore, is child prostitution "*...a moral, educational, judicial or health issue?*" (Barrett 1997, p.161). Barrett (ibid.) believes it is all of these and more. Children involved in prostitution are at serious risk of ill health. Lack of knowledge in relation to safer sex especially for children in or leaving care places the child at a real risk of contracting and spreading sexually transmitted infection. As with adult sex workers, children selling sex are at risk from anxiety, loneliness, low self-esteem, depression, self-harm and attempted suicide (Faugier and Sargeant 1997). Sex workers addicted to drugs are very often young, working at the 'bottom of the market' with limited experience on how to handle clients, and isolated from the knowledge of the older women in relation to risk minimisation (Harcourt and Philpot 1990). They are at risk of continual and intense levels of violence perpetrated by clients, other sex workers, the general public and pimps. Concern in relation to the age of girls entering prostitution is shown by older sex workers but only due to their belief that the younger sex workers, especially girls from local authority care, undercut prices and offer sex without a condom to finance drug habits.

Many young sex workers do not use drug services or sexual health clinics as these are seen as irrelevant to their needs. Statutory services are difficult to access but young sex workers prefer outreach and community based drop-in centres offering holistic care. Health care professionals, teachers, social workers, police and the judiciary need to be aware of the extent of and the risk to children involved in prostitution. Early recognition and intervention is necessary with education aimed at empowering the child, within a multi-disciplinary team (Faugier and Sargeant 1997) in an outreach setting.

(iv) 'Polluted' Womanhood

Before the conception of a sex worker as a 'polluted' woman, sex workers were viewed sympathetically as weak women who had 'fallen' into disrepute due to moral weakness. However, due to different forms of deviancy and excess (e.g. alcoholism) and the concept of difference of sex workers' anatomy in the late 1800's defined by medical anthropologists, the sex worker was believed to be the only cause of venereal disease in men. The uniqueness of sex workers from virtuous non-sex workers enabled the sex worker to be seen as a site of infection, requiring control. Not only was the sex worker described negatively in terms of disease, but the conception of the sex worker as having congenital defects resulting in physical degeneration was incorporated into the attributes of the sex worker (Spongberg 1997). Congenital syphilis was attributed to prostitution, as "[d]*octors*

related the moral degeneracy of the prostitute to the mental and physical degeneracy wrought by congenital syphilis" (ibid., p.7). By the 1920's sex workers were pathologised, they were incomparable to 'normal' women due to mental, moral and physical pollution.

HIV can be sexually transmitted, sex is the central part of the sex industry, therefore the spread of HIV and AIDS has been heavily linked with the sex worker. The sex worker does not force the client to have sex but sex workers deal daily with risks and actual violence. Research has suggested that an infected man is slightly more likely to infect a woman during sexual intercourse than the other way round (JOHNSON_1990McKeganey et al 1990), indicating sex workers may be at greater risk of HIV infection from their clients. Nonetheless, the sex worker continues to be seen as a 'reservoir of disease', placed into categories as either *"...vectors transmitting HIV to men, or as vessels for its transmission into the next generation"* (Squire 1993, p.6). Morgan Thomas (1992) identifies the most disturbing assumption as the belief that most, if not all, sex workers have AIDS and if they do not already have it they have no interest in preventing infection. Research however shows otherwise; the majority of sex workers show an understanding of sexually transmitted disease and acknowledge the threat that it poses to them, also the wish to protect against unwanted pregnancy indicates a high level of condom use with paying clients (Day and Ward 1990; McKeganey and Barnard 1992, 1996; Sharpe 1998).

4. LEGISLATION: DECREASING SAFETY, INCREASING POLLUTION

Prior to May 2004 when the Sexual Offences Act of 2003 came into force "[i]*n law only women are defined as prostitutes and prosecuted for the offences of loitering and soliciting"* (Edwards 1987, p.45). A 'prostitute' is now considered gender-neutral as are other offences relating to prostitution (e.g. kerb crawling, causing or controlling prostitution). However, concern, whether welfarist or punitive, continues to be centred on tightening the control of street workers. Legislation passed in relation to prostitution has three aspects, which have focused the debate, and are discussed in this section. It can be identified (i) in terms of the perceived risk that the sex industry presents to public health, (ii) by the unpredicted effects it has had on increasing the possibility of transmission of infection, and (iii) in relation to alternative legislation deemed to accommodate the reduction of the incidence of infection.

> *"It was of course the social reaction to prostitution, the various attempts to control and regulate prostitution which caused its stigmatisation..." (Heidensohn 1985, p.94).*

(i) Public Health

In the mid-nineteenth century authorities recognised the inevitability of prostitution. Prostitution became a state-regulated institution. The concern was to maintain a more manageable form of prostitution divested of its disruptive and politically embarrassing character. *"Protection for males was supposed to be assured by inspection of females"* (McHugh 1980, p.17) outlined in the Contagious Disease Acts (1864, 1866 and 1889). Legislation continues to attempt to control sex work to protect the general population from infection by the sex worker. However the *"...primary aim should be to control sexually transmitted diseases...not to control sex workers"* (Morgan Thomas 1992, p.76).

(ii) Increasing Risky Behaviour

An unforeseen consequence of legislation is the need for sex workers to undertake risky behaviour, moving underground into unpoliced areas and more dangerous situations. In fact *'[i]n some respects the law is now at odds with the requirements of public health"* (Matthews 1990, p.85).

The Sexual Offences Act 1956 created a range of offences connected with prostitution, specifically criminalising the aiding, encouraging, managing or exploiting of sex workers. A year later the Wolfenden Report on Homosexual Offences and Prostitution (1957) was recognized as a radical approach applying *"...a more rigid distinction between law and morality, crime and sin"* (Matthews 1986, p.188). The report claimed that however immoral prostitution may be, it is not the law's business. Concern had to be directed towards public order, decency and exploitation, not issues of private morality. The desire was to keep prostitution and the associated risks out of public view.

The recommendations of the Wolfenden Report were adopted by the Street Offences Act (1959) which made *"...it illegal for a 'common prostitute' - not just any women - to solicit for prostitution"* (English Collective of Prostitutes 1997, p.85). The construction of 'common prostitute' was sex-specific and a woman can be charged as such after two verbal cautions for loitering or soliciting within a year on the evidence of two or more police officers. This Act removed sex workers from view due to the change in police prosecution procedures' and sex workers deterred from the streets used other forms to contact clients.

The Criminal Justice Act 1982 abolished imprisonment for soliciting and although use of probation declined, the use of fines increased, as did the amount (Edwards 1987). In 1985

The Sexual Offences Act was the first piece of legislation that prosecuted the persistent kerb-crawler/client. Nonetheless, this was introduced to defend the respectability of neighbourhoods and innocent non-sex workers and to decrease nuisance, not to protect the sex worker. Section 71 of The Criminal Justice Police Act 2001 gave police the power to take into custody kerb-crawlers, and, once charged, fingerprints and DNA samples can be taken.

The illegality of soliciting caused by these Acts and the resultant over policing has contributed to the increase of sex workers undertaking risky behaviour. Condoms and sterile needles given out by health workers to sex workers have been used as evidence in legal proceedings. Therefore some sex workers did not carry them and so they were not available when required, resulting in unsafe sex and unsafe injecting practice being undertaken. *"One of the by-products of...covert styles of working is likely to be that the scope for negotiating safer sex with clients is...reduced"* (McKeganey and Barnard 1992, p.118). The sex worker does not take the time to assess the client and negotiates the exchange once they are in the car rather than on the kerbside. *'*[P]*unishment by fining merely increases the women's work-load..."* (Matthews 1990, p.85) increasing the number of clients she has contact with and therefore increasing risk of harm from violence or unsafe sex. The inability to legally work from premises with other sex workers is linked to isolation and uncertainty; the sex worker is more at risk from unpredictable clients in unsafe environments. All the resultant behaviour of legislation, which decreases safety, increases risk.

More recently, there has been an increase in welfare intervention via sexual health and drug outreach projects and a decrease in criminal justice intervention and regulation of prostitution. This change is illustrated by the decline in the number of women cautioned or convicted of soliciting *'*[i]*n 1989 there were 15,739...*[b]*y 2002, this number had fallen to 4,102"* (Offending and Criminal Justice Group 2002 cited in Phoenix and Oerton 2005, p.88). Nonetheless, punitive measures, as with children involved in prostitution, are used for those who continually return to prostitution. Thus sex workers continue to fear arrest, as many have no other 'choice' but to continue and therefore risky behaviour continues.

In 2004 the government published 'Paying the Price', a consultation document, which although making no attempt to change prostitution legislation, recognised prostitution as a problem that victimises and destroys those directly involved, and the communities within

which prostitution takes place. Victims are defined within the document as those who are trapped in prostitution, vulnerable to abuse and coercion, requiring support via coordination of community projects and statutory services. However, as with children involved in prostitution, the new understanding of a prostitute as a victim with limited individual resolve ignores the socio-economic conditions that can lead to their 'rational' involvement. 'Paying the Price' outlines a range of new proposals (e.g. cautions, arrest referral, Anti-Social Behaviour Orders) that are hard-hitting on intolerable behaviour and continuation of prostitution.

(iii) Alternative Strategies to Legal Intervention:

Rather than increasing legal constraints on sex workers, two alternatives have been suggested. These options of legalisation and decriminalisation are related to the discursive constructs of pollution, safety and stigma and are discussed in the following section.

(a) Legalisation

The legalisation of sex work would involve registration, organised through brothels paying tax on the money that they earn. It is believed brothels would decrease public nuisance, as the sex worker would no longer be working on the streets, and in turn reduce the risk to the sex worker from violence and infection. Sex workers working in brothels would be *"...morally respectable and legally 'acceptable' "* (Sharpe 1998, p.158). Nonetheless, the women would have *"...to submit to rules designed to protect public health..."* (Scambler and Scambler 1997, p.186), in the form of periodic health checks, to retain their licences. However, licensing sex workers could lead to further stigmatisation on both moral and practical grounds, as the label of sex worker would be recorded. Also the time period between acquiring HIV and becoming seropositive may take many months so a medical card does not necessarily guarantee an infection-free sex worker. On moral and ethical grounds Venema and Visser (1990) believe it is important that individual sex workers should not be forced to register.

Under the rules of legalisation clients would remain unchecked, they would not be subjected to health checks, the sex worker is still seen as unclean and as the 'polluter' (Matthews 1986). Sex workers have no control over business, lose financial independence, work long hours and may be coerced to have unprotected sex (Harcourt and Philpot 1990, p.144). The latter is due in part to the client not seeing themselves as the risk to health, and the perceived risk, the sex worker, has a license to prove she is 'free' from infection

(Morgan Thomas 1992). Finally, in Hamburg *"...only 12% of prostitute women are estimated to work in the legalized area..."* (English Collective of Prostitutes 1997, p.91). Brothels are an addition to street prostitution and not an alternative. The sex workers most at risk are unable to gain entry to the brothels due to intravenous drug use and STIs so undertake covert prostitution fuelling the 'pollution' debate.

(b) Decriminalisation

The liberal position is that prostitution is a non-victim crime and as such legal intervention is unnecessary. The sexual exchange is a result of an agreed verbal contract. Decriminalisation *"...would entail no official change in the legal status of prostitution but an acceptance ...of the women's work"* (McKeganey and Barnard 1996, p.102). This could result in the designation of certain areas of the town or city as 'tolerance zones' (Scambler and Scambler 1997, p.186). Between 1985 and 2001, Edinburgh had an unofficial but recognised informal tolerance zone. SCOTPEP (Scottish Prostitute Education Project) was one of the projects that offered a range of health protection and health promotion initiatives, social support, rehabilitation services and harm reduction strategies within a pragmatic and flexible approach as part of the tolerance zone. Since the discontinuation of the zone, SCOTPEP report the sex worker population has become fragmented and individual women are isolated, resulting in increased exploitation of sex workers by drug suppliers and a significant increase in violence (e.g. in 2001 eleven attacks were reported; one hundred and eleven in 2003). The Prostitution Tolerance Zones (Scotland) Bill introduced in the Scottish Parliament in September 2003 aims to enable *"...local authorities to designate areas within their boundaries as "prostitution tolerance zones" and amends section 46 of the Civic Government (Scotland) Act 1982 to ensure that loitering, soliciting or importuning by prostitutes within such zones is not illegal".*

In late 2004 Birmingham rejected plans for tolerance zones. Liverpool, however, applied to the Home Office in January 2005 for approval for managed zones based on the Dutch model in Utrecht. The managed zone in Liverpool would operate at night in an industrial area of the inner city with CCTV cameras, a health and welfare centre and patrolled by street wardens. However, sex workers would continue to be marginalised, as they would be formally separated from the general population due to working within isolated areas and recorded on camera therefore, diminishing anonymity. A radical piece of legislation was passed in Sweden in 1999, which decriminalises those who sell sex, but criminalises those who buy sex, the penalty if caught is a fine or six months imprisonment for the client.

Government funding is made available for 'exit' strategies, which include drug, and alcohol treatments. An intention is sex workers would be treated as victims of a crime and with a change of legal status stigmatisation would be reduced. A possible side effect of this strategy is as indicated previously with respect to kerb crawling legislation, sex workers need to work, and this may move the sex work underground into unpoliced areas and more dangerous situations, increasing risk.

5. 'SAFE' FROM POLLUTION

All sections of the population need to be made aware of the health risks associated with the practice of unsafe sex and intravenous drug use. However, as has already been discussed, it is certain groups that have primarily been targeted as a public health risk, among them sex workers. From the mid 1980s onwards targeting of sex workers has not been primarily via the criminal justice system but by funding specialist sexual health and drugs outreach projects thus creating health centred interventions. Sex workers are not criminalised but via multi-agency approaches are educated about ways in which they could reduce risks to their health (e.g. involving issues connected with housing, benefits, drug abuse and violence) and supported to address health needs or to exit prostitution if this is what they wish. So instead of sex workers being governed by the criminal justice system, Phoenix (Phoenix and Oerton 2005, p.88) believes *"...by the mid-1990s the institutional conditions were in place which enabled a more 'welfarist' 'regulation' policed through NGOs and other statutory bodies".*

Education in relation to the construction of pollution and prostitution has different aspects and this section of the thesis describes; (i) promotion of personal responsibility, (ii) promotion of safer sex, (iii) increase awareness of risk and a main barrier to education (iv) damaged mental health.

(i) Promotion of Personal Responsibility

As one sex worker is the single point of contact for many clients, the promotion of personal responsibility within the sexual exchange and while using drugs is important. The sex worker requires both knowledge and supplies (e.g. condoms, clean needles) to undertake responsible behaviour, and the correct social skills to gain co-operation from the client. Dutch policy in relation to sexually transmitted infection has been one of promoting personal responsibility within a flexible, anonymous and accessible service which is aware of the different forms of both overt (e.g. street, window) and covert (e.g. call girls, private

houses, brothels) prostitution (Venema and Visser 1990). To facilitate responsibility, choice for the sex worker is the main concern in policy initiatives. Compulsory examinations of sex workers while ignoring the possible infection of the clients does not prevent the spread of sexually transmitted infection. Repressive measures drive prostitution underground preventing sex workers from seeking medical care, but testing en masse would also be very expensive. To encourage voluntary medical checks, a variety of Dutch health care is offered ranging from general practitioners, to specialist and private doctors and sexual health clinics provided via health insurance, health departments and brothel owners/sex workers (Venema and Visser 1990).

Dutch health policy has identified three groups that need to be targeted in relation to safer commercial sex; management, clients and non-paying partners. For the retention of long-term business, the managers of brothels need to be made aware via health education that a reputation of spreading sexually transmitted infection is not good (Harcourt and Philpot 1990). Clients are notoriously difficult to contact and approach. The limited research on male clients has found that the men are aware of the dangers of HIV/AIDS but many believe that they can tell if a sex worker is an intravenous drug user and if she has a sexually transmitted infection. The clients themselves do not see themselves as a risk to the health of the sex worker. In Holland clients are targeted on the streets and given condoms, and messages regarding the importance of the practice of safer sex.

In the UK difficulty in promoting personal responsibility of the sex worker arises as some have a deep suspicion of statutory services due to previous life experiences and stigmatisation. The distrust is aptly shown by Matthew's (1990) study, when no sex worker attended a meeting organised to discuss HIV prevention. It later emerged that the sex workers thought the meeting *"...would be full of social worker types"* (ibid., p.77). Contact has been increased with sex workers, with the use of sexual health outreach projects identified as the most effective method to engage sex workers with risk reduction strategies. Sex workers are approached in areas where they work and care is offered in a holistic way. Support and advocacy are key policy features within an environment that the sex worker can trust. *"By 1997, most major British cities had at least one such project"* (Phoenix and Oerton 2005, p.88).

(ii) Promotion of Safer Sex

In Holland the health message given to sex workers is no different from the message given to the general population. Vaginal intercourse, masturbation and oral sex all with a condom are regarded as safer sex, unsafe sex is penetration especially anal sex, without the use of a condom (Venema and Visser 1990). By educating the general population the clients are reached as well. In the UK education concerning sexually transmitted infection has to be continuous due to the constant movement of sex workers entering and leaving the profession. In relation to HIV/AIDS the issues surrounding safer sex have been discussed in the previous sections on control of infection, victims of 'pollution' and legislation: decreasing safety, increasing 'pollution'. *"The AIDS crisis has not invented 'safer sex' - prostitute women have traditionally used condoms as a barrier against VD and unwanted pregnancies"* (English Collective of Prostitutes 1997, p.97). However, worries in relation to HIV/AIDS increased condom use. Day and Ward (1990, p.65) in comparing two groups of twenty five sex workers (of similar age, work place and injecting habits) interviewed during the first visit to the Praed Street Clinic found that the proportion of sex workers reporting condom use for vaginal intercourse for the week prior to the interview was 48% in 1986 and 96% at the end of 1987 and the beginning of 1988.

The practice of safer sex remains a high priority for the agencies involved with sex workers. *"Through the clinic we learned how prostitutes avoided infections at work, advice which we can in turn pass onto other women"* (Ward and Day 1997, p.151). Education on condom use varies in part on the experience of the sex worker but ranges from how to put one on, the things to say to encourage the client to use one, the different types to use for different types of sexual intercourse, to safe disposal once the condom is used (Europap 1999).

(iii) Increase Awareness of Risk

Sex workers have *"...an acute awareness of the potential dangers of providing sex to men who for the most part are total strangers"* (McKeganey and Barnard 1996, pp.32-33). Sex workers are fully aware of their own vulnerability as women selling sex (Barnard 1993). Securing control of the sexual encounter via an assertive posture, although not always successful, is a crucial factor in terms of personal safety (McLeod 1982). It is the sex worker who decides whether to do business with a particular client once the price, which is non-negotiable, is accepted by the client. During the business transaction no room is left for ambiguity so that no misunderstanding is possible on the true nature of the relationship and what has been agreed. Whether to accept a client is based on multiple factors including

past experience, personal preference (e.g. age and ethnicity of client, type of sex requested, type and condition of car) and intuition (e.g. whether the punter looks strange/weird, assessing mannerisms). Intuition as the only means of assessing a client highlights the sex worker's vulnerability and is not foolproof (Barnard 1993). The money is taken first and the sex worker decides where the transaction is going to take place. "[W]*e have to go to a place of my choosing-where I can feel that I am in control of the situation*" (Belinda in Sharpe 1998, p.68).

Some projects offer self-defence classes and give advice on personal safety both generally and for specific types of working environment (Europap 1999). Many projects offer a 'dodgy punters' or 'ugly mugs' list that provides descriptions of clients who have attacked or caused problems for sex workers. This is circulated among the sex workers to warn them against these individual men. However awareness is not only seen in relation to violence but is taught around drug use such as a safer injecting technique, and legislation, involving advocacy work.

(iv) Damaged Mental Health

Promotion of personal responsibility, safer sex and increased awareness of risk are all diminished due to the damaged mental health of the majority of sex workers. As Spongberg (1997, p.178) writes *"[M]any reformers writing on prostitution during the war* (1914-1918) *stressed the fact that prostitutes were generally mentally defective"*. Many women before entering sex work have diagnosable mental health problems however sex work itself has *"...momentous and long-term consequences for women...prostitution's destruction of emotional life, self-image, and self-respect is...massive"* (Hoigard et al 1992, p.183).

Mental health and illness can be constructed and discussed in different ways with varying terminology (e.g. mental health problems, mental distress/disorder, psychological problems, madness). Coppock and Hopton (2000, p.122) write *"[T]here is a long-standing recognition of the need to re-conceptualize notions of mental health and mental distress in terms of a continuum, rather than simply instituting arbitrary cut-off points"*. It is a contested area within which professionals apply different theoretical perspectives/explanations (i.e. biochemical, genetic, social, cognitive, psychoanalytical and behavioural) and intervention approaches (e.g. psychometric assessment, psychoactive medication, Electro-Convulsive Therapy, counselling, psychotherapy). Phenomena, which also require consideration concerning their contribution to the development of mental health problems, and are particular issues

for sex workers are social isolation, alienation, exploitation, oppression and discrimination (Pateman 1983, Shrage 1989, Jenness 1990). Nonetheless, what all the explanations indicate is that *"...a person is experiencing some sort of disorder or difficulty in relation to their feelings, behaviour and/or mental experience"* (Millar and Walsh 2000, p.1).

Mental illness has been formalised into psychiatric classification systems (e.g. the International Classification of Mental Behavioural Disorders of the World Health Organization (ICD)) (see Coppock and Hopton 2000 for criticisms of systems). Mulvany (2000) provides three categories of disorders in order of perceived seriousness. The first includes schizophrenia, which is defined as, *"...severe psychotic mental illness marked by a distortion and fragmentation of normal pathways between thinking, emotions, perceptions and behaviour"* (Millar and Walsh 2000, p.13). The second group is identified as the affective psychoses, which Mulvany (2000) describes as mood disorders (e.g. manic depression), of which sex workers frequently report associated symptoms. This group includes depression *"...characterised by pervasive, ongoing low mood, a lack/reduced sense of enjoyment of life and a pattern of negative thinking"* (Millar and Walsh 2000, p.5). The third identified category contains anxiety disorders, which incorporate phobias, these are the outcome of focused anxiety creating irrational, unreasonable or unfounded fear of an object, situation, animal or phenomenon. Bursfield (2002) creates a 'typology of disorders' with slightly differing categorisation within the last two groupings. The typology encompasses disorders of thought (e.g. functional psychoses including schizophrenia), disorders of emotions (e.g. depression, anxiety states, phobias, neuroses) and disorders of behaviour (e.g. alcohol and drug dependency, eating disorders). Within Bursfield's (2002) typology, sex workers predominately report symptoms that are classified within disorders of emotions and behaviour (for example see 1 (iii)). Ward et al (1997, p.149) reported *"[M]any women requested help and professional counselling, with work and other problems including relationships, drug use, depression and abuse"*. To minimise harm sexual health agencies involved with sex workers offer informal counselling and referrals to 'trusted and sensitive' psychologists and counsellors for different categories of damaged mental health.

II. DIMENSIONS OF RIGHTS

The rights of a sex worker to full citizenship and the entitlements that are associated with this status (i.e. legal and physical protection; health care; housing and benefits) are greatly reduced. This section will reveal the discrepancies in what are thought to be the rights of sex workers within medical, moral and legal discourses. As with any individual who

undertakes what is perceived to be risky and immoral behaviour, the rights of the sex worker to services that are needed as a result of that behaviour are diminished. As long as prostitution is stigmatised, sex workers will remain vulnerable and lack power to bring about change.

This section will examine the dimensions of rights; (1) ownership of the female body, (2) consenting adults, and (3) diminished rights including (i) economic vulnerability, and (ii) violence and rape.

1. OWNERSHIP OF THE FEMALE BODY

Phoenix (1999, p.134) documented the way in which four interviewees by *"...their reactions to and remarks about being sold..."* defined their prostitute identity within bodies as *"...objects of temporary exchange (that is, 'rentable')...with no ownership and no control as slaves to their 'ponces as owners'"* (ibid., p.131). This was how these sex workers not only made sense of the realities of prostitution but appeared to accept it as usual practice. They reported being sold between 'ponces' when earnings reduced or tensions arose. Phoenix (1999) continues by explaining this understanding enabled them to think they had no control over their involvement in prostitution.

Pateman (1983), with other radical feminists, believes prostitution is morally undesirable as it represents the exploitation and domination of women by men and the objectification of a woman's sexuality. WHISPER (Women Hurt in Systems of Prostitution Engaged in Revolt) believes that no woman chooses to prostitute and that all sex workers are victims of a patriarchal system of control and abuse (Jenness 1990). Hester and Westmarland (2004, p.2) add to the argument by writing *"...involvement* [in sex work]*...is predated on feelings of low-self esteem created and fed by abusive or other critical life experiences".* They continue by stating *"[p]rostitution is in this sense not simply a free economic transaction nor choice of 'employment'"* (ibid., p.2) but is linked to economic necessity, male coercion or economic inequalities. Therefore, Hester and Westmarland (2004) believe women enter sex work because they feel they have little value and nothing else to lose, drifting into sex work via peer groups or 'groomed' by older adults. Through their research however, they find sex workers believe they were *"...able to 'regain control' in that they perceive they have 'power' over the punters and have money to satisfy their own needs"* (Hester and Westmarland 2004, p.60). Radical feminists believe acceptance of prostitution means the buying and selling of women's bodies is state-sanctioned. Prostitution is considered not to be

comparable to other forms of paid employment, socially useful or provide either personal fulfilment or empowerment. The effects of prostitution are violence and stigmatisation, with job insecurity, poor pay and poor conditions of employment. In literature it is presumed powerless sex workers should therefore be rescued by abolishing prostitution.

The inequality/coercion argument used to explain women's involvement in prostitution is opposed by others who argue that prostitution is sex and as such is a matter of privacy and individual freedom (Pheterson 1989). Prostitution is an act that provides a sexual service and as such is a matter of sexual freedom and self-determination, which is unfairly restricted by legislation, and stigma. "[T]*here is a free market and women should be free to sell themselves..."* (Edwards 1997, p.68). Women should have the choice and the right to decide what to do with their own bodies and not be seen as passive victims in need of rescuing. The objective of COYOTE (Call off Your Tired Ethics) is to empower women and legitimise prostitution as work. The sex worker does not sell herself but provides a sexual service in exchange for money (Scambler et al 1990). Prostitution is therefore an equal exchange (Ericsson 1980). However, there are problems in separating the sale of the body and the self, and the sale of services through a contract. Pateman (1983) believes that sex workers do not just provide a sexual service, due to the interconnection between the body and the 'self'.

2. CONSENTING ADULTS

"Prostitution is the public recognition of men as sexual masters; it puts submission on sale as a commodity in the market" (Pateman 1983, p.564). Shrage (1989) opposes prostitution as the principles that sustain and organise prostitution are the same that form gender inequalities as a whole. However, others believe that an agreement between the sex worker and the client is a contract between equal and consenting adults in a commercial market. The contract depends on what the sex worker is prepared to do, the client's request and the amount of money offered. These are not fixed. "*Throughout the process of negotiation the women adopt an assertive, businesslike stance"* (McKeganey and Barnard 1996, p.32) The sex workers as providers of a service feel they are in the position to dominate, control and dictate the type of exchange. COYOTE believe that the majority of women, after dismissing alternative work, make a conscious decision to prostitute (Jenness 1990). Nonetheless, a distinction needs to be made between prostitution entered into freely and women forced into prostitution and controlled by other parties. Of the women who sell

sex, COYOTE believe that 15% are coerced into prostitution by other parties (reported in Jenness 1990).

A further issue of concern within the debate of consenting adults and coercion is the global trafficking of women for the purpose of sexual exploitation. Kelly and Regan (2000) believe it is a gross violation of human rights and a serious crime issue about which little is known but exists within a climate of tolerance. Contracts within the sexual exchange are not perceived to be a reality for trafficked women. Women from countries (i.e. Thailand, Central and Eastern Europe) with limited employment opportunities, socially and politically marginalised, are coerced when abducted or recruited through deception (e.g. the promise of a legitimate well paid job, employment in the entertainment industry) via the media or being approached in clubs and bars. Some may be aware they are entering prostitution but not the extent of the debt, intimidation and control involved. Women are delivered to the individual or organisation who have 'paid' for them within an illegal transaction and the women's official documents are confiscated. Trafficked women are expected to work longer hours, see more clients than the indigenous sex worker and have all their earnings taken for payment of debt (i.e. travel documentation, travel costs, delivery fee, rent, laundry, transport home). According to Kelly and Regan (2000, p.4) the type of control exerted on the women makes *"...free and voluntary agreement impossible..."* and *"...whilst all human beings have agency, the ability to act within an oppressive context limits the available options"*. Control ranges from imprisonment, physical and sexual violence, to threats made against family and friends in their country of origin, deportation and prosecution. Kelly and Regan (2000, p.37) believe *"[t]rafficking in women could be considered a contemporary form of slavery...Trafficked women whilst in conditions of sexual exploitation have their movements controlled, their earnings confiscated, and they have minimal, if any, control over their labour"*. Thus, it is apparent from this literature that for some groups within sex work consent is non-existent.

3. DIMINISHED RIGHTS

To include sex workers within the general population, prostitution needs to be seen as a social problem. *"COYOTE claims that most of the problems associated with prostitution are directly reduced to the prohibition of prostitution, to the stigma attached to sex and especially sex work"* (Jenness 1990 p.404). Central to COYOTE claims is the notion that prostitution is work and as service workers and not criminals, sex workers are entitled to respect and protection. Women have a right to choose prostitution as work and also have a

right *"...not to be subject to public harassment such as: stigma, rape, violence, denial of health care, denial of protection by and under the law, and denial of alternative job opportunities"* (Jenness 1990, p.406). However, right-wing moralists believe the sex industry needs to be more stringently regulated by increasing both the level of policing and prosecutions, with more punitive sanctions. If prostitution is a contract freely entered into, the risks associated with sex work are nothing more than the sex worker can expect when 'commodifying' her body. It is also a criminal act and as such the sex worker should not expect fair treatment as she has foregone any entitlement due to her behaviour. "[P]*unishment...is meted out for failure to comply with the fixed moral standards which are established for women"* (Andrieu-Sanz and Vasquez-Anton 1989, p.76). The diminished rights of sex workers are reduced by their economic vulnerability and further illustrated by the incidence of violence and rape.

(i) Economic Vulnerability

"Prostitution is a resistance and/or a response to poverty" (O'Neill 1996, p.135). Specific economic conditions shape women's engagement in prostitution (McLeod 1982; O'Neill 1996). Social location, low pay, long hours or part time work do not provide women with opportunities for earning an adequate living. Sharpe (1998) however, after interviewing forty female sex workers, saw their poverty as relative, as they were not prostituting to prevent starvation. The women described themselves as being forced into prostitution and justified their continuation as due to poverty, inadequate benefits and unemployment. In Matthews' study (1990) many sex workers working in the red light district in Liverpool did not have a permanent address so were unable to claim Social Security benefits. Many women also have low educational attainment and minimal work skills, which further limits secure regular employment, and earning potential. Some women on the other hand do not want the routine and rigidity of a 'normal' job but value the autonomy and freedom of prostitution (Scambler et al 1990; Sharpe 1998). Not all the sex workers working in a red light area work throughout the year, but some may only sell sex for a few weeks of the year in order to pay additional expenses (e.g. at Christmas, to pay an amenity bill). However, money charged for sexual services and earnings varies greatly between different types of prostitution and the demand (Scambler et al 1990). These factors combined with the women's central role within the family have meant that women need alternative means to earn money or subsidise other forms of income.

Street sex workers in a study by Sharpe (1998, p.75) claimed to be able to earn on average £100+ per night although this amount could fluctuate vastly. Rent, bills and non-sex work related fines accounted for the majority of the money earned for 67.5% of women interviewed; drugs were a priority for 5 out of the 40 interviewed (ibid., p.72). The majority of sex workers do not have criminal intentions but it is a choice related to lack of other employment opportunities. There are various routes into prostitution apart from poverty and economic need. *"Some of the women were forced or inveigled into prostitution at a young age by men who knew the potential income they could earn"* (McKeganey and Barnard 1996, p.101). Women are physically and/or sexually and/or emotionally coerced into prostitution as a relationship with a pimp develops.

Cook (1997, p.36) argues prostitution *"...is also a crime which further impoverishes the majority of women who engage in it".* It becomes almost impossible to join the conventional job market, to marry, to claim benefit or to improve housing conditions. A further negative factor is that the income gained via prostitution is *"...unofficial, undeclared and cannot provide the basis for any sound financial future"* (ibid., p.38).

(ii) Violence and Rape

The limited citizen rights of the sex worker are illustrated by both the incidence and response towards violence and rape. Due to the risk that the sex worker is seen to be to the general health of the population and the illegality attached to selling sex, occupational health risks to the sex workers themselves have been overlooked (Barnard 1993). Health risks to the sex worker are unrecognised or at the extreme deemed to be unimportant within moral discourse. Physical and verbal attack, kidnapping and rape are endemic within the sex industry perpetrated by partners, clients, pimps and occasionally other sex workers (O'Neill 1996). Hoigard and Finstad (1992) reported that out of 26 sex workers interviewed, 19 had been the victims of violence, ranging from being hit to rape, imprisonment to verbal threats of being killed. *"Women who prostitute have every justification for feeling themselves the victims of repressive legislation that does nothing at all to protect them"* (Edwards 1987, p.49). *"Society, through our police forces, seems to be saying that such attacks are to some extent justified..."* (Morgan Thomas 1992, p.73). Although, the police are more likely to respond to a serious sexual attack, motivation is protection of the 'respectable' female. The perceived moral character of the sex worker especially in the eyes of the court is a major deciding factor on whether the sex worker was 'asking for it'. Despite the Sexual Offences Amendment Act (1976) legislating against previous sexually

history being used in court, the questions of consent and credibility in rape cases are even more of an issue for sex workers than with non-sex worker women (Adler 1987; Temkin 1987).

Sex workers, when recounting incidences of physical and verbal violence, even at the extremes of kidnapping and rape, do so as if violence is to be expected and is nothing untoward (Hoigard and Finstad 1992; O'Neill 1996). Violence is an expected aspect of daily life as despite the sex workers attempts to obtain client compliance, male clients are physically stronger and the sexual exchange usually takes place in dark, deserted areas. In Sharpe's study (1998) some sex workers defined rape as more than a physical violation but the breaking of the verbal contract between themselves and the client. Agreement had been made on the transaction but after the sexual exchange the client had refused to pay the agreed amount. Rape was the breaking of the agreement based on trust (ibid., p.84). Enforcing unprotected sex due to the removal of a condom after the transaction has been agreed is also seen as rape (Venema and Visser 1990). Edwards (1984) states that individuals opposed to prostitution believe sex workers, due to the nature of their work and placing themselves in situations where assaults are more likely to occur, should almost expect violence. Sex workers themselves recognise the danger - even so they have the right of protection from violence, rape and intimidation.

Those on the left broadly share the view that laws relating to prostitution are oppressive penalising women, especially working class women. Covert legal regulations due to the concept of morality and the threat to public health that sex workers are perceived to present, result in reduction in "*...rights, liberties and freedoms around housing, education, health care, and issues relating to the custody and access to children...*" (Edwards 1997, p.75).

The following section will discuss how much choice the majority of women have when making the decision to be a sex worker. The decision is a complex interaction of individual choice, recruitment and introduction by family and friends (O'Neill 1996), financial, domestic and personal circumstances. Some women/girls are coerced. Friends specifically make prostitution sound a fairly good career decision, an easy way to earn money. The positive attitude when introducing friends into prostitution does not necessarily correspond with the negative way early personal experiences are described in interviews (Sharpe 1998).

III. POWER RELATIONSHIPS

Women's general lack of power within private and public spheres further increases the vulnerability and exploitation of certain groups of women, e.g. those in or leaving care, on separation and those suffering from damaged mental health. This section will discuss; (1) social vulnerability and (2) gender vulnerability in relation to sex workers. It will relate to the previous section of rights, as the issues are very much inter-linked.

1. SOCIAL VULNERABILITY

Social vulnerability of sex workers corresponds with their diminished rights and general lack of power. Hoigard and Finstad (1992, p.15) claim that it is well documented that women who enter prostitution primarily come from *"...the working class and the lumenproletariat..."* with the associated social problems (e.g. lack of education, lack of secure well paid employment opportunities) which lead to social vulnerability. Increased involvement with prostitution and the lifestyle links to a corresponding decrease in social networks outside of work, with little social support *"...damaged women being damaged more"* (O'Neill 1996, p.142).

Many women enter prostitution when they are socially vulnerable after long periods of stressful life events such as an unstable family background (e.g. childhood sexual abuse) resulting in a lack of social support networks and low confidence, low self-esteem, depression and divorce. When a sex worker has low self-esteem the wish to protect her health and general well-being is diminished (Matthews 1990). Social vulnerability is further increased by damaged mental health. Many sex workers are emotionally needy, vulnerable and homeless. This is especially true for young women leaving care who are ill equipped for independent living, have had multiple placements and already associate with the street culture. They *"...cling to a peer group offering a sense of belonging and mutual support"* (O'Neill 1997, p.14). It is an alternative community, a subculture of similar individuals who understand their lifestyle experiences and the effect these experiences have on choices. Phoenix (1999) suggests that prostitution is sometimes a strategy for independence and survival from relationships, welfare and local care. However, in Holland the subculture and associated codes that decrease a sex worker's social vulnerability are seen to be disappearing due to drug use and the development of 'individualism' among the sex workers (Venema and Visser 1990). Matthews (1990) reported similar experiences in Liverpool where violence and aggression among sex workers, which had been rare, was increasing and was blamed on the use of crack. Sharpe (1998) believes sex workers are

vulnerable while working as they stand alone, only exchanging information regarding police presence and 'dodgy' punters. Friendship on the 'patch' is weak and superficial with no mixing socially outside of the 'patch' further increasing sex workers' social vulnerability. Social, as with economic vulnerability can be seen in relation to *"...one which arises out of...their class position...within a specific location in contemporary Britain"* (Eaton 1986, p.p.8-9).

2. GENDER VULNERABILITY

In a patriarchal tradition the women who prostitute and not the men are seen as the problem (Pateman 1983). Women have differential gender experiences involving socialisation, role expectations and social control (Smart 1976). Some women are marginalised by gender, class and/or race bias. Men not only protect women but also have the right to punish women for inappropriate sexual behaviour (Barnard 1993). Men continue to hold the majority of positions of power and women remain economically dependent on them. Gender inequalities are shown in the distribution of power, authority and control between men and women (Barnard 1993). Prostitution further exacerbates this gender vulnerability, *'[P]rostitution is an institution that allows clients to secure temporarily certain powers of sexual command over prostitutes"* (O'Connell Davidson 1998, p.3). It is therefore a relationship of unequal power and *"...an institution which reduces women to a sexual commodity..."* (Edwards 1997, p.69) to be bought and sold. The sex industry gives little/no power to the women but is structured by patriarchal attitudes, values and controls. Men in the role of pimps/ponces largely control both financial and physical aspects of prostitution. There is a need to de-stigmatise the women and decriminalise the activities so that sex workers are not seen in terms of 'pollution' and have the ability to realise citizen rights and entitlements.

IV. SUMMARY

This chapter has provided an historical overview of the main literature concerned with sex worker health issues. The purpose of this review has been to identify the discourses relating to sex worker health, which are medical, moral and legal, applicable to the four themes of the research. Within the discourses, the discursive constructs of pollution, rights, power, stigma and safety are prominent. In the past these discursive constructs have provided explanations for the behaviour of sex workers and of those acting upon them, and as will be illustrated support the understanding of need, risk, access and provision to health

care for sex workers. Additionally the constructs provided a method of categorising the literature providing a greater understanding and structure to perform the research.

The sex worker was classified as a 'pollutant' by religious moralists, leading family and womanhood into sin, deserving of stigma, this was compounded by biomedical knowledge that identified the sex worker as a transmissible source of infection. Patriarchal attitudes supported the pollutionary construction and the need to control infection. Advances in medical knowledge identified that the sex worker was not the sole source of infection. The emancipation and rise of the feminist movement challenged the patriarchal moralist discourse. The moralist viewpoint is still generally negative, driven in religious terms viewing the sex worker as sinful, 'polluting' the religious concept of family, and also in non-religious terms as degrading, unclean and 'polluting' the patriarchal view of womanhood. The discursive construction of pollution, and the sex worker as a moral and physical 'pollutant' remains the driving force to varying degrees in the majority of discourse and discursive constructions, and as will be shown in the research affects the constructions of need, risk and provision and directs access.

Sex workers have been and are stigmatised at many levels. Stigma has been constructed by those who act upon sex workers due to the pollutionary concepts already discussed, and more recently has been extended by the lifestyle and illegality of drug use and the negative stereotypes of individuals with mental health damage. The illegality of the sex work increases the stigma, as it confirms to others that sex workers are harming society. Sex workers also fear stigma that they perceive will exist, influenced by actual stigma, the media and others. Stigma will be shown in this research to be related to the provision and access to health care, with implications for risk.

The construction of power is centred on the sex workers ability to make choices within their lifestyle, which in legal discourse has marginally improved from the low point of the 1800s, but has decreased in medical discourse due to the effects of drug use and damaged mental health. The sex worker has been viewed and remains socially and gender vulnerable, because of their working class backgrounds, mental and physically abuse, reduced opportunities due to sex work and patriarchal attitudes. Without the ability to make choices, sex workers health is compromised. The research will illustrate that disempowerment is linked to access to health care.

Inter-related with power is the construction by others and that of the sex worker of their citizen rights and their 'right to choose'. In legal discourse the sex worker is constructed as immoral and undeserving of, and in many cases denied certain rights due to her sex work lifestyle. The sex workers construction is in turn influenced by these moral constructions and experiences of stigma resulting in some believing they do not have the same rights as non-sex workers. The sex workers legal rights are diminished due to their inability to be accepted as 'normal' citizens when requesting justice. The construction of rights directly relates to provision in this research.

Safety is a construction that relates directly to the research health care themes. Sex workers have been constructed as leading lifestyles that are physical and psychological unsafe, initially with the emphasis on affecting others but more recently directed towards the safety of the sex worker. Sex workers safety in the 1980s with AIDS became a higher priority with targeted support and condemnation, with emphasis now on support and individual responsibility. The sex workers constructions of safety are limited by their social vulnerability, drug use and damaged mental health. As the research will examine safety requires an understanding of need and risk to make provision and allow access.

These discursive constructions will support the analysis of the interviews informing the needs of and risks, access to and provision of health care for female sex workers at the end of the twentieth century.

Chapter 2

CONSTRUCTING THE ANALYTICAL FRAMEWORK: DISCOURSE ANALYSIS & NORMATIVE THEORIES

Chapter One provided the theoretical framework by evaluating medical, moral and legal discourses, applicable to the four themes of the research. In doing so it identified that the discursive constructs of pollution, rights, power, stigma and safety are prominent. Chapter Two is divided into two sections, one discussing discourse analysis and the other discussing normative theories, which are applicable to the research themes, discourses and discursive constructs. This chapter identifies discourse analysis and normative theories, 'the analytical framework', that when combined with the 'theoretical framework' form the foundation for the analysis of the empirical data.

The first section of the chapter discusses the perspective of Foucaultian discourse analysis (Foucault 1972), a theoretical perspective, which sees language as a system that has its own rules and constraints, unified by common assumptions. The study of discourse promotes the investigation of the origins regarding a certain subject, knowing what we know and how we speak. Discourse analysis enables exploration of the meanings social actors attach to events and experiences. The second section of Chapter Two discusses normative theories, i.e. sets of rules or guidelines for informing social action to produce ideal states. The inter-related normative theories selected will facilitate the investigation of the construction of need and risk by (i) sex workers (ii) service providers (iii) the conditions by which sex workers use, receive, or are excluded from health care services and (iv) the conditions by which service providers deliver health care. These sections relate to the underlying epistemology, and outline the methodological position as identified in the Introduction (section II).

The analytical framework will make possible the deconstruction of the empirical data (i.e. discourse) resulting in knowledge of how health need and health risk are described, who decides when someone is in need, or at risk, on what authority and why (e.g. for an individual's well-being or to protect public health). For, as Worrall (1999, p.8) has observed, the primary aim of discourse analysis *"...involves the deconstruction of coherence to reveal the underlying paradox..."*.

I. ANALYTICAL METHODS

1. DISCOURSE ANALYSIS

Discourse analysis differs from other perspectives on language. Within positivism, for example, neither the historical nor psychological foundations of knowledge are sought. Positivists believe that only observable, experienced entities can be scientifically analysed, with a tendency towards social structural explanations of knowledge rather than human intentions and motives of individuals.

Foucaultian discourse analysis was chosen, as this analytical approach centres on the construction of subjects (e.g. sex worker) within differing forms of power/knowledge relations (e.g. sex worker and important others) in various historical relationships. Foucault (1977) describes knowledge as a form of power but power also dictates when, if and how knowledge is used. According to Foucault power is legitimately exercised via the discourse of right (e.g. the legal system). Knowledge and networks of power are mutually interdependent, they are entwined, one does not exist without the other; where power is present, knowledge is produced. The type of power directs the development of certain forms of knowledge. Knowledge, when linked to power, usually assumes truth. However, if the truth of the statement is questioned then the use of power enables knowledge to become true, which has real effects. Truth is also dependent on the location of the statement within particular political arenas. Foucault discourse analysis enables investigation into how knowledge is organised in relation to power and how the combination of power/knowledge regulates the behaviour of bodies within different institutional, contextual and historical settings. According to Foucault although the ruling classes and ruling institutions hold dominating, powerful positions, power does not solely pass down from the ruling classes or ruling institutions to the less powerful, but operates in different ways throughout social life and social situations. Power is a strategy and not a structure or institution. Power *"...needs to be thought of as a productive network which runs through the whole social body"* (Foucault 1980, p.119).

Foucault believed the body is the central target for different forms of power/knowledge, in the form of regulation. The body is both economically and politically useful. The way in which the body is constructed within discourse depends on the level of new forms of knowledge, new technologies of power, truth, institutional apparatus and institutional techniques. Different discourses and institutional practices classify and treat the body according to the extent of power and what counts as truth. Through modes of objectification

and different relations of power, human beings are classified as subjects and objects of knowledge. Foucault (1977, p.23) describes the different ways in which the body of the criminal has been developed into *"...a specific mode of subjection"*. For instance, scientific and legal discourses gave French penal regimes the power to punish the body (via public executions involving torture). More recently via new forms of power and knowledge the body is still subject to imprisonment although not to punish the body but to modify attitudes and behaviours. Therefore, the body is *"...totally imprinted by history and the processes of history's deconstruction of the body"* (ibid., p.63). The body is a central concern in relation to prostitution: the way in which the sex worker is acted upon within medical discourse as though 'polluted', moral discourse as though damaging the family and legal discourse as though different from non-sex workers.

Foucaultian discourse analysis situates the language used by an individual in a particular cultural, social and political context, focusing on representation. It entails analysis of language in use, practice (e.g. actions and behaviour) and institutional regulation. Foucault (1972) wrote that material objects exist in the real world but have no real meaning outside specific discourses. Discourse and the social world are intertwined. It is discourse which produces knowledge and meaning.

Other forms of discourse analysis would not have enabled the investigation of discourse as producing knowledge that facilitates the understanding of broad historical and cultural meaning. For instance, conversation analysis is only interested in social interaction during naturally occurring everyday discourse, at the point at which people talk. The analysis does not extend beyond the immediate conversation (e.g. the talk itself, the situation under which the talk takes place, the roles of the people speaking), and is separate to, and has very little interest in, the social, political and cultural context in which the conversation takes place. Critical discourse analysis is used in the belief that discourse makes up only one element of social interactions and distinctions need to be made between the discourse and social life. The 'real world' is based on the differential power of social classes within economic relationships, independent of discourse. The aim of critical discourse analysis is political, the analysis hopes to demonstrate and change, through knowledge, social inequality and injustice. Using conversational or critical discourse analysis limits the understanding of broader discursive patterns, significant content and different levels of explanation at specific historical and cultural points. Foucaultian discourse analysis is not used uncritically and in

the analysis full consideration is given to the *"...material, economic and structural factors in the operation of power/knowledge"* (Wetherell et al 2001, p.78).

But what is discourse? According to Foucault (1972) a discourse is a group of sanctioned statements or utterances, produced by a set of rules and procedures, which have some institutionalised force, resulting in far-reaching influences on individuals' behaviour and thoughts. Discourses are grouped according to similar ideas, dynamism and performance, similarity of outcome/effect or within a particular social context. For instance, Corbin (1990) in documenting prostitution in nineteenth century France, describes how prostitution was regulated by the interrelated discourses of medicine, the municipal authorities, the police and the courts, due to the fear that the sex worker was diseased. Therefore, it was the requirement of all the aforementioned authorities to protect public morality, male prosperity and public health. Sex workers were officially supervised via compulsory registration and health checks and were the focus of numerous bye laws in relation to the running of registered brothels (e.g. all windows had to remain shut and be barred, women were not to be seen at windows or doors and women were not allowed to sleep in the same room). There was also an attempt to control independent sex workers under the bye laws (e.g. ranging from times and places where women were allowed to solicit, not to solicit in groups, to not walking the streets without wearing a hat).

Foucault (1972, p.49) also describes a discourse as *"...practices that systematically form the objects of which they speak"*. Within prostitution, legal, medical and moral discourses, combined with stereotypical images of how women who sell sex dress (i.e. short skirts, high heels, lots of make-up), have led to the sex worker being labelled as 'other', different from non-sex workers (O'Neil 2001). Thus a discourse produces something else, a discourse does not exist nor can it be analysed in isolation. The development, retention and use of discourse varies with the institutional and social context within which the discourse circulates and the importance of both the speaker and recipient of the discourse. In other words, *"[d]iscourse is rooted in desire, a desire to communicate with an other"* (Burton and Carlen 1979, p.16).

Foucault (1972, p.80) describes discourse as sometimes meaning *"...the general domain of all statements, sometimes as an individualised group of statements, and sometimes as a regulated practice that accounts for a number of statements"*. In this thesis discourse will be used according to the second definition. The analysis will therefore, concentrate on groups

of utterances, which appear to have some form of coherence, regulation, and force in common, specifically a prostitution discourse relating to need, risk, access and provision of health care.

In 'The Archaeology of Knowledge' (1972, p.131), Foucault stipulates that archaeology *"...does not imply the search for a beginning..."* or an attempt to disclose the truth or accuracy of a statement. Archaeology aims to document the support mechanisms and the practical field in which the statement is used. The methodological approach attempts to determine the process by which one statement is upheld as dominant (credible knowledge) but another statement is treated with such suspicion (lack of credibility) that its development is impeded. Foucault classified the utterances as 'in the true', the utterances make some form of truth claim, ratified as knowledge. The dominance of the biomedical model in Western medicine illustrates the last point well. *"Biomedicine is... a powerful discourse..."* (Fox 1998, p.13) giving authority to experts (e.g. doctors) who control the discourse, and until recently excluding alternative types of medicine (e.g. complementary medicine). Complementary medicine (e.g. osteopathy, acupuncture, herbal remedies) has been given credence in the last fifteen years, in part due to scepticism about the ability of biomedicine to cure illness and disease.

For Foucault (1972), the significance of, and the way in which objects and events are interpreted within systems of meaning is reliant on discursive structures. Discursive structures do not originate from extra-discursive mechanisms of socio-economic and cultural factors, although those factors can be shaped by discursive rules and structures. Discursive structures in turn enable us to perceive objects and ideas as real, within the boundaries of discursive constraints. Therefore, at each historical conjunction discourses shape reality and inform behaviour and thought, within known frameworks. For example, in 'The History of Sexuality', Foucault (1978, p.3) writes that the official approach to sex in Victorian Britain was directed by the wish to exercise power in private and public spheres, *"[s]exuality was carefully confined, it moved into the house"*. The silencing of discussion about sex distinguished the Victorians from previous periods of unconcealed sexual practice. Extramarital sex was to be conducted in the brothel or mental hospital *"[o]nly in those places would untrammelled sex have a right to a...form of reality, and only to clandestine, circumscribed, and coded types of discourse"* (ibid., p.4). Walkowitz (1980) writes that the Contagious Disease Acts reinforced the change in concerns, outlined by

Foucault, by framing illicit sex as a dangerous activity in need of public scrutiny and a befitting focus of state policy.

In the establishment of legitimate discursive structures, the unworthy and unreal have to be excluded. The holder of the discourse has to be recognised as an authority on the subject. The possible use of, and the rules governing the use of the statement have to be established. The aforementioned criteria linguistically describe the world. For instance, due to the perceived immorality and unworthiness of sex workers, the discursive structures of the law criminalise and control the sex worker. Since the late 1980's within prostitution discourse the authorities with power (i.e. doctors, the judiciary, the police) have not changed, but the discursive constructions have. In the late 1980's HIV/AIDS (Woolley et al 1988; Plant 1990; Morgan Thomas 1992) was the dominant discursive construction. In the late 1990's and early 2000's the discursive constructions are ones of youth prostitution (Barrett 1997; Melrose et al 1999; Phoenix 2002; also a concern in the Victorian era - see Walkowitz 1980) and drug addiction, specifically crack cocaine (Miller 1995; Maher 1996).

Foucault (1972) wrote of mechanisms that structure and constrain the production of certain types of discourse. In the curtailment of the use of certain information, acceptable knowledge is limited to sanctioned utterances and texts occurring within clear and recognised boundaries of discursive frameworks. Humans understand and order reality and events by categorising and interpreting experiences into narratives via available institutional and cultural structures. For instance, some sex workers have compared the work of a sex worker with that of a marriage guidance counsellor or a social worker/psychiatrist, preventing divorce, sexual assaults and rape. Sex workers, in describing their involvement in prostitution as a service, which maintains the family and keeps non-sex workers safer, resist the public imagery of a sex worker as both a moral and physical 'pollutant'. Resistance is described by Foucault (1978) as present whenever and wherever power is exercised over the mind and body of an individual. Both power and resistance according to Foucault are part of sociality. As well as resisting the common image of the sex worker, sex workers resist (the power of) legislation, as despite the illegality of soliciting and loitering and the real possibility of being arrested, sex workers continue to solicit.

Episteme form the backbone of thought on which at a certain historical point selected statements will count as knowledge (Foucault 1972). The episteme consists of sets of statements grouped into different discourses or discursive frameworks, which develop due

to the interaction of the discourse, authorised to be used at that time. An episteme directs the way in which a culture 'thinks' about an issue or event, and informs the development of procedures and supports needed for the way of thinking to continue. For instance, prostitution was only regarded as a sin with the growth of Christianity and Protestantism. Prior to the idea of the sex worker as alienated and disempowered, in Ancient Greece sex workers had status and autonomy (O'Neil 2001). In Victorian Britain the sex worker was seen as a transmitter of infection to the respectable middle classes. The 'unrespectable' poor were used for the pleasure of middle class Victorians within a period of time dominated by class and gender differences. The poor were also the focus of deep-running fears and insecurities among working class Victorians (Walkowitz 1980). The Contagious Diseases Acts (1864, 1866, 1869) not only a result of the fear attached to the sex worker as a vessel of disease, but reinforced both a sexual double standard (e.g. only 'fallen' women were detained and examined) and class inequalities (e.g. middle class male sexual need was exonerated). Presently, in part due to improved medical knowledge and some change in sexual morality, once a sexually transmitted infection has been confirmed, all known sexual contacts have to be notified regardless of whether the individual is male or female, irrelevant of being a sex worker.

Despite the feeling of permanency surrounding some discourses, they change as meanings are contested. Discursive structures do not develop on a linear scale. Foucault suggests there are episteme breaks related to key events in history, which result in discontinuous development. Episteme breaks occur when the selected statements, which count as knowledge, change, and a culture 'thinks' differently about an issue or event. Episteme breaks are present in medicine. Near the end of the eighteenth century a new framework for medical knowledge and practice emerged: medical thought re-conceptualised disease (Foucault 1973). 'Classificatory medicine' evolved into 'medicine of symptoms', which eventually developed into 'medicine of tissues'. In classificatory medicine the human body was a space within which a disease could be located. The patient was 'removed' from their body so that individual characteristics (e.g. age, lifestyle) would not interfere with the symptoms of the disease. According to Foucault, medicine of the tissue emerged when death was no longer understood as the end of life and therefore disease, but instead became seen as the point at which life and disease could be examined. Death was conceptualised as the relationship between life and disease. *"[D]isease was able to be both spatialized and individualized"* (Foucault 1973, p.24), illness was conceptualised in the form of individuality, not cases or classification.

Discourses, as well as overlapping and supporting each other, may also conflict. Feminist approaches to prostitution contain opposing discursive structures. Prostitution is framed as either exploiting and dominating women, perpetuating patriarchy (Pateman 1989; Shrage 1989) or if sex work is 'freely' chosen, prostitution is located within a discourse of human rights involving privacy and freedom (Pheterson 1989; O'Neil 1996).

To understand the 'ground of thought' of prostitution it is important to understand the archive. Foucault defines the archive as *"...the set of rules which at a given period and for a definite society define: 1) the limits and forms of expressibility; 2) the limits of forms of conservation; 3) the limits and forms of memory; and 4) the limits and forms of reactivation"* (Foucault 1978, pp.14-15). The archive limits the form of speech and what is important to know and remember. For example, alternative ways of thinking and expression are ruled out in the disease model of addiction. Drug addiction is an increasing problem for some sex workers. The discursive construct of addiction in health promotion discourse is constructed within a disease model, biologically framing the behaviour as a dependency with the individual having limited or no control over the habit. Physiological addiction is a negative but dominant discursive construction discouraging individual self-empowerment (e.g. the will power to enable action) and control in decreasing or stopping drug use (Gillies 1999).

The archive of prostitution can be subdivided into popular, academic and official archives. Despite the division and use of specific discourses in each archive, the archives can and do overlap. Discursive constructs can lie dormant in the archive, re-surfacing at specific times, to be used or validated by different speakers when particular issues become topics of concern or public knowledge.

A good example of statements surviving and being re-used within prostitution discourse is the construct of pollution, which appears in both popular and official archives. In these two archives the sex worker in Victorian Britain was seen as a suitable target for public health policy (see I.1(i) Syphilis and Gonorrhoea) until the construction of the sex worker as 'polluted' was repressed by medical advances. The construct re-emerged in the late 1980's with the discovery of AIDS/HIV. Popular discourse during the late 1980's and early 1990's framed HIV/AIDS as a suitable punishment for deviant behaviour, continuing the Victorian belief that commercial sex was immoral. The official discourse was one of protecting public health, which enabled finance to be targeted towards education and services for sex workers. The allocation of public resources for helping sex workers was only politically and

socially acceptable as the health of the general population was indirectly protected. Without the initial belief that the sex worker threatened the health of the normal family through the transmission of HIV, there would have been a public outcry about 'inappropriate use of public funds'. Syphilis, gonorrhoea and HIV/AIDS have in the past and are still used to scapegoat, criminalise and victimise sex workers.

In the late 1990's the construction of pollution as HIV/AIDS was repressed as the feared epidemic did not occur. In the early 2000's the construct of pollution has re-emerged, although with different concerns, within drug addiction. For the public the main concern is the discarding of used dirty needles in public spaces, creating a perceived risk of injuries from needles and the consequential infection for children playing in the area. If the individual who used the needle were HIV or Hepatitis C positive the perception is the virus will remain on the needle to infect the next user (whether the user intentionally or accidentally injects). In addition to the problem of dirty needles, the official archive is again one of public health due to the correlation between intravenous drug use and the practice of unsafe sex. Intravenous drug use diminishes an individual's wish or ability to negotiate or practice sex with a condom. So statements relating to pollution have survived although the perceived causes of 'pollution' have changed. The discursive construct of pollution is re-used and recognised as valid within popular and official archives.

A study of the academic archive (Lombroso and Ferrero 1895; Benjamin and Masters 1964) illustrates shared constructions of morality, deviance and disease with that of both popular and official archives. However, since the work of McLeod (1982) in particular, the academic archive contains statements that do not relate prostitution to the construct of pollution but study the possible reasons for prostituting e.g. whether selling sex is a personal choice, a solution to poverty or because of coercion (Phoenix 1999). Additional statements within the academic archive show discourses constructed around damage limitation e.g. drug addiction (Plant et al 1980), protection e.g. appropriate health care (Scambler and Scambler 1997) and protecting the under 18's (Melrose et al 1999). Recent academic discourse does not apportion blame nor does it illustrate constructions of deviance or immorality. This point can be illustrated by the use in the last five to ten years of the more neutral term of 'sex worker' in preference to the negatively stereotyped term of 'prostitute'.

The most significant ways a discourse is produced are by processes of exclusion, which act on discourses to limit speech and knowledge (i.e. the archive rule of expressibility). In Victorian 'respectable' circles, sex was not mentioned openly in mixed gender groups as it seemed to the Victorians self-evident that sex was too impolite a subject to discuss. Within prostitution discourse there have been attempts by projects working with sex workers, pressure groups (e.g. WHISPER) and social researchers (Jenness 1990; Jesson 1993) to exclude constructions of morality and deviance and to redefine prostitution as work offering new expressibility rules.

Rarefaction, an expressibility exclusion rule, refers to the process within which, despite the theoretically infinite number of utterances one person can produce, the speaker remains within socially defined boundaries and is repetitive in the choice of utterances. Therefore, individuals, so as not to cause offence, carefully select a limited number of utterances based on their own and others' perceptions of what is acceptable. However, choice of topic and language are also restricted by constructions of desire and need. In turn desires and needs are governed by discursive and material boundaries or limits. So even though choice of utterances is dependent on acceptability, 'wants', which in themselves cannot be limitless, also add to the choice of topic and language. Rarefaction of statements will be considered during the interview stage of the study as sex workers are marginalised, stigmatised and excluded due to their activities, which may limit their discourse.

To summarise, Foucault discourse analysis enables this study to focus on the rules, conditions, behaviours and authorities under which sex workers and service providers construct need, risk, access and provision. Specifically the way in which the constructions are formed and operate, of secondary interest are the power/knowledge influences on the construction, and how statements survive or are reactivated. The construction will be evaluated against the discursive constructs pollution, stigma, safety, rights and power within moral, legal and medical discourses.

II. NORMATIVE THEORIES

In this second section of the chapter inter-related normative theories of need and risk will be described. It will become apparent that need and risk are highly contested normative concepts. This section will examine the theories and identify those which are applicable for this research with (i) sex workers (a vulnerable population), who due to stigma and

legislation attached to prostitution want to remain concealed within the work and home environment and (ii) service providers (a professional population) who have contact with sex workers, but exhibit varying degrees of professional detachment.

The concept of need is inherently ambiguous and difficult to measure. The measurement of need can incorporate value judgements by service providers on the deservedness of the recipient. Service providers have identified sex workers as having many and varied health needs (e.g. sexually transmitted infections, respiratory problems, back and skin problems). Sex workers also present an interesting population in relation to risk. In particular whose risk is it? Sex workers' bodies are governed not only due to being at risk themselves but due to posing a risk to others and are 'blamed' for undertaking risky behaviour. Risk is seen as not only starting with a sex worker but stopping with her as well. For instance she is assumed to be the vessel from within which a sexually transmitted infection originates but little is talked about possible other origins of infection or the risk posed by an infected client having unprotected sex with a 'clean' sex worker. It is the intensity of both sex workers health needs and health risks, which make these concepts important to this thesis.

1. NEED

This section reviews the construct of need within medical, moral and legal discourses before specifically discussing health need applicable to sex workers. Need is a complex concept, causing many debates on its usefulness and validity as a concept in relation to policy. *"[I]n practice it is not clear that the word has any coherent meanings, let alone that its many users share a definition"* (Hill et al 1986, p.56). The Concise Oxford Dictionary (Fowler and Fowler 1990, p.793) defines need as *"...stand in want of; require...circumstances requiring some course of action; necessity...destitution; poverty"*. Political ideologies have conceptualised need in many different ways. For instance those on the right traditionally believe that there are both shared basic needs and individual needs but the market provides the opportunities for individuals driven by self-interest to satisfy these needs. Market economies encourage individual choice, initiative and responsibility. Needs are neither objective nor measurable but are subjective preferences that individuals can act on or ignore. Government provides minimum state provision to meet residual needs of those individuals unable to access the market due to poverty or disability. On the other hand social democrats believe basic needs are shared by all and met through government provision, individual human needs are met individually through the market once basic needs are satisfied, and mutual needs are met through collective

provision. Market provision increases inequalities due to lack of specialised knowledge of the consumer, monopoly power and the requirement to pay. Debates on need ultimately lead to discussions on the ways in which the government should allocate services for competing claims while taking into account opposing debates on individual responsibility and the desirable range and size of the welfare state.

Even if specific needs are identified within a group of individuals "*...in some cases it will be felt that it is not legitimate, necessary or appropriate for the state to intervene*" (Clayton 1983, p.229). Policy makers and welfare providers should not only recognise the need as credible but also have moral and political justification in allocating public resources to alleviate the need. The characteristics (e.g. predominately working class, female), morality issues (e.g. selling sex) and needs (e.g. problematic drug use, STIs) attached to the sex worker population have remained the same. Nevertheless, as Clayton (ibid., p.229) writes of need, and which can be applied to sex workers, the *'*[v]*iews as to what constitute*[s] *need change*[d] *over time...".*

Care should be taken to ensure that needs are defined by an optimum standard and not the availability of existing services. Individuals use the concept of need to claim social resources for themselves or others. Need is seen to be a legitimate way to articulate claims. Through processes of negotiations and reconstruction due to inappropriate, unreasonable or utopian claims, state resources are either allocated or withheld. At the end of the negotiation process the original concept of need may have been completely redefined in legal and medical discourse. *"Needs are dynamic and reflect the realities of continuous social change at a structural level"* (Culpitt 1992, pp.68-69). The definition of need will change over time due to national and regional legislation, resource allocation and the demands of local populations.

The satisfaction of need justifies and requires state intervention as opposed to the satisfaction of wants or desires, which can be left to the market. However, as has already been explored in this section, the difficulty in defining need also applies to defining wants or desires which in turn makes drawing a distinction between need and wants difficult. Needs according to Plant et al (1980) are one of three possible moral bases for welfare, the other two being justice and rights. Civil and political rights (e.g. absolute right to legal representation) are not questioned to the extent of social and economic rights but also involve claims on scarce resources. Charles and Webb (1986) recognise some basic needs

as so fundamental as to consider them social rights and as such to be provided as a duty to all citizens. The Commission of Justice report (1994, p.18) stipulates *"...that everyone is entitled, as a right of citizenship, to be able to meet their basic needs for income, shelter and other necessities..."*. Nonetheless, this substantive right of need-satisfaction ignores the problem of scarce resources, the resultant priority setting and the problems of defining outcomes. For instance Sanderson (1996) argues effective and efficient need-based public services should be based on outcomes that adhere to the notions of social justice negotiated through collective action involving all stakeholders.

Service providers within agencies and projects carry out needs assessments to ascertain the extent of individual and community needs. Gaps between need and service provision can be identified and funding can be sought for the appropriate service. It is assumed that *"[e]quity of process...will result in equity of outcome in the distribution of resources"* (Klein et al 1996, p.26). Need assessments are increasingly focused on vulnerable groups (e.g. the elderly, the homeless, individuals with mental health problems) and as such care has to be taken that need is not defined in a way that stigmatises or disempowers an individual or group. Assessment is paramount in an environment of diverse populations, new policy initiatives, scarce resources and service accountability. Assessment can be carried out at the request of a community, from within an organisation or regional and national government. The internal structural organisation of the agency (e.g. source of funding, reason for carrying out the assessment, experience and qualification of staff) and external political pressures have to be recognised within the assessment process. The assessment and therefore the estimation of needs should be suitable (e.g. appropriate language) for the characteristics of the population (e.g. individual and cohort experiences) under assessment. Secondary data (e.g. government statistics) or primary data (e.g. surveys, in-depth interviews, focus groups) that can be used in the assessment taking into account all perceptions of need will have a degree of subjectivity dependent on an individual's socio, economic and political context. There are however concerns related to the way in which need is defined, the differing methods used to assess need and the way in which information on need is used to influence the policy process and allocation of services. As Klein et al (1996, p.27) wrote, *"[w]e are still left asking: a need for what? Is it a need for more money, for better health services or for more social support?"*.

(i) Health Need

Within medical discourse there are three main perspectives on health need; the biomedical/epidemiological approach, the health economist approach and the social perspective on health and health need, all of which will now be discussed.

Firstly the biomedical/epidemiological approach. Doctors dominate the thinking of a health need primarily as a disease. The service provider makes decisions for the patient or client based on their scientific knowledge. Within medical paternalism a form of drug therapy is prescribed that aims to get rid of the pathogen and health is restored. The extent to which the biological abnormality can be stopped, or reversed, and health restored, is dependent on the level of medical knowledge, clinical examination and the availability of resources (Taylor and Field 1993; Bursfield 2000). The biomedical model of health places the hospital as the appropriate situation for patients to receive treatment, and shapes the structure and delivery of health care (Turner 1987; Bursfield 2000). Due to the organisation of medical service providers that exclude or control other service providers, medical professionals are identified as experts possessing credible scientific knowledge, knowledge not accessible to patients. Operational definition and measurement of need is very often made by a professional at the point of delivery and is therefore open to self-interest, bias and professional practice. The biomedical way of describing health provides no middle ground, as the individual is either healthy or suffering from a disease.

The health economist assesses need and the allocation of services in the context of priority setting, scarce resources and the belief that as needs are relative not all needs can be satisfied. However, *'[t]he economic approach limits need assessment to a purely 'technical exercise' within the present health service...*" (Foreman 1996, p.72). By using cost benefit analysis needs are traded against one another, ineffective treatments or services are stopped whilst others are retained only while the cost is lower than the benefit (e.g. the maximum number of individuals benefit). The identified need is met in the most appropriate cost-effective way and the health of the population is maximised. Quality Adjusted Life Year (QALY) is one method undertaken to assess the relative effectiveness of specific service provision for the same or different illnesses. "*Health improvements are measured in terms of life expectancy, adjusted according to changes in quality of life resulting from the use of health services*" (Donaldson et al 1993, p.31). Therefore priority is given to services that provide the longest survival rate with a good quality of life at minimal cost. Nonetheless the

use of 'QALYs' raises methodological, practical and ethical problems (see Bursfield 2000, pp.168-170).

The social perspective on health and health need is propounded by Bradshaw (1994, p.48) who bases his definition of health on the World Health Organisation's definition that "*...health is a state of physical, mental and social well-being and not merely the absence of disease or infirmity*". In addition, health determines the ability of a person or group to "*...on the one hand realise their aspirations and satisfy needs and the other hand, to change or cope with the environment*" (ibid., p.48). In using the social perspective on health and health need, an understanding of social, economic and environmental factors and not just the epidemiology of disease can be considered. The social perspective also enables the opinions of the person (e.g. a sex worker) with the health need to be considered so the need assessment is not just dependent on the professional definition or the services that are already available. An example of a method of assessment following the social perspective is the community-led health needs assessment. This method depends on the support of professionals but "*...requires the skills to undertake needs assessments be given to the community...*" (Foreman 1996, p.75). However, the social perspective using a very broad definition of need is limited in the context of the present day climate of priority setting in the National Health Service.

Forms and levels of health care vary with geographical location, social class, gender and ethnicity. Nonetheless Taylor-Gooby (1991, p.171) writes that "*...the object of welfare policy is to meet human needs*". It is however, extremely difficult to transform and measure the basic need of, for example "*...a modicum of good physical health*" (Doyal and Gough 1991, p.56) into health care provision. Instead the argument concerning the definition of basic need is focused on whether equal access for equal need has been achieved (Whitehead 1987). "[M]*edical need should be the sole determinant of treatment, and no...other factor ought to distort the prioritisation associated with need*" (Powell 1997, p.54). Nonetheless, the identification of need does not automatically mean a right to a (part or complete) service to meet the assessed need and may in fact result in further scrutiny to ascertain if the need meets further criteria (Percy–Smith 1996).

One commonly used theory on need is Bradshaw's (1972) 'taxonomy of social need', within which he recognised four types of need. The way in which need is defined reflects the values and views of different groups. 'Normative need' in any given situation is established

by experts or professionals who compare a set of "desirable" principles against standards that already exist. *'[I]f an individual or group falls short of the desirable standard then they are identified as being in need'* (Bradshaw 1972, p.640). Experts are used to validate and define need as they are believed to be impartial, to be aware of the criteria used in a need assessment, are more aware of the benefit that an individual could gain by using a service, specifically if it is new, and protect services against unjustified claims by an individual. However, normative need cannot be seen as absolute and has been criticised for being paternalistic. Needs are implicitly assessed by using middle class values by professionals distanced from the experience of the need. What also has to be noted is *'[e]xperts' assessments of need are influenced to some extent by such factors as demand for the service, political feasibility, and financial and manpower restraints...*" (Clayton 1983, p.223). In each community, experts vary in what they consider to be adequate care and provision. Variation in assessment occurs due to the level and standard of values and individual and professional knowledge. So what qualifies as need in one community may not qualify in another, rendering useless the notion of universality in a given area of welfare provision.

'Felt need' is determined by the individual. It is articulated when the individual is asked if they are satisfied with present services or whether they would like or feel a need for a different service. Felt need focuses on the subjective notion of need but may not be translated into action. Bradshaw (ibid.) identifies felt need as very similar to want, and argues that it is very difficult to determine whether 'needs' and 'wants' have been merged by the individual. Individuals have to possess the ability to express their felt need, which when expressed can be inherently conservative. In turn individuals can be influenced by comparing their service provision to that received by others, their perception of what type of care the service offers and by what is already available. The expression of felt need can result in a wish list. Clayton (1983) writes identification of need should be related to obligation and what individuals would be prepared to pay for the specified service.

'Expressed need' can be described as a felt need that is expressed in the form of a demand or request for a service or goods. This definition relies on sufficient ability and power of individuals or groups to define their need and the corresponding service. Problems exist in using this definition as an indicator of social need e.g. those with the highest level of need may not be able to express it; some are resigned to being in need. Generally sex workers lack the ability and power to express their needs.

When comparison is made between individuals with similar characteristics in similar situations, and some of the individuals receive the service and others do not, 'comparative need' exists. To use comparative need in analysis a decision is required on the salient characteristics of the population and the different populations to compare. Comparative need indicates gaps in service provision in one area when compared to another area, also taking into account the differences in the population (e.g. social, demographic and/or environmental factors) being assessed. However, comparative need will vary depending on the different geographical areas being assessed and could indicate more concerning the prior allocation decisions and appropriate levels of provision than actual current need.

Doyal et al (1991) suggest needs are universal because human nature is common to all (e.g. all individuals need food, shelter, warmth) and all individuals share one material world. Although communities attach different meanings to need there are core social life activities which satisfy need and are *"...immune to cultural variation..."* (ibid.,p.82). It is resource allocation and the ways to satisfy need that are shaped by different cultures. To talk about need is to talk about rights to satisfaction. Doyal et al (ibid., p.170) define *"....minimally disabled social participation"* as the basic human interest. Thus unless an individual is *"...capable of participating in some form of life without arbitrary and serious limitations being placed on what they attempt to accomplish, their potential for private and public success will remain unfulfilled..."* (ibid.,p.50). According to Doyal et al (ibid.), to facilitate minimally disabled social participation, physical survival/health and personal autonomy are the two universal, objective basic needs all individuals have.

Basic needs exist independently from the subjective judgements of different individuals as need is identified and satisfied through technical, moral and political choices. So that basic needs can be realised Doyal et al (ibid.) identify an additional eleven 'intermediate' needs common to all cultures. Examples of those that are primarily applicable to sex workers are nutritional food and clean water, a non-hazardous work environment, appropriate health care and a non-hazardous physical environment. According to Doyal et al (ibid.) intermediate needs provide standard reference points by which deprivation can be measured and services provided. The standards are defined as 'participation optimum' and 'critical optimum'. For 'participation optimum', individuals have the health and autonomy to *"...choose the activities in which they will take part within their culture, possess the cognitive, emotional and social capacities to do so and have access to the means by which these capacities are required"* (ibid., p.160). For 'critical optimum' to occur, individuals have

the health and autonomy to *"...formulate the aims and beliefs necessary to question their form of life, to participate in a political process directed towards this end and/or join another culture altogether"* (ibid.,p.160). Prostitution discourse has illustrated that sex workers are limited with regard to both standards. However, Doyal et al (ibid.) do not believe individuals by themselves can decide whether they are in need. Individuals do not have the appropriate information or knowledge, and in addition physical health will almost always be capable of improvement. Perfect health is for the majority unattainable and most individuals would benefit from an increase in appropriate health care. Therefore, *"...there needs to be a trade-off between improving physical health...and the social participation for which* [these] *are preconditions"* (Wetherly 1996, p.51).

The normative need theories discussed have illustrated the definitional problems associated with need and how need has been conceptualised in the academic archive. Analysis of sex workers and service providers discourse will enable an understanding of their differential construction of need (i.e. rules, conditions, authorities). The review has enabled a number of theories to be identified as applicable to this study within the research boundary. Health need as defined by sex workers and service providers, will be investigated using Bradshaw's theory of felt need and normative need respectively. The theory will not be used in its specific form to identify provision, but in the generic form in relation to what health needs exist. For example sex workers will be asked during the interviews to identify their past present and future medical problems/issues (i.e. 'health needs'), as well as access to provision, a 'felt need'. During service provider interviews they will be questioned to obtain their definition of the medical need standard and the actual provision, therefore identifying 'normative need'. This study will also consider the three medical approaches to health need when analysing service provider interviews. By using Bradshaw's (1994, p.48) definition which advocates a level of *"...physical, mental and social well-being..."* enabling an individual to live a successful and safe life, an understanding of social, economic and environmental factors will be considered during the interviews and analysis. The focus of this study is to identify the construction of need, not to measure the level of need-deprivation of sex workers, which has already been well documented, in prostitution discourse. Thus although a selection of Doyal et al (1991) intermediate needs will be used as pointers, the standard reference points will not.

The next section of the chapter will discuss risk and health risk as *"[r]isk is replacing need as the key organising principle in health and the personal social services"* (Kemshall 2002, p.22). Service delivery based on need is in disrepute due to claims of dependency, 'undeservedness', inappropriate targeting and lack of redistribution. Risk assessment and risk management are the tools used to dictate delivery of services. A process of calculating the probability of a risk occurring is evident in health services within which individuals gain access to health provision on the level of risk they are exposed to or as in public health prevention in order to prevent or reduce risks. Risk has become the predominating factor in welfare delivery, dictating priority setting based on economic restraints and litigation avoidance (ibid.). Despite the role of risk in service delivery practices, a balance is still required between meeting the needs of an individual and discouraging individual risk taking.

2. RISK

Ewald (1991, p.199) writes "[n]*othing is a risk in itself; there is no risk in reality. But on the other hand, anything can be a risk; it all depends on how one analyses the danger, considers the event*". This quotation illustrates well the ambiguity involved in constructions of risk. The Concise Oxford Dictionary (Fowler and Fowler 1990, p.1040) defines risk as "*...a chance or possibility of danger, loss, injury*", so according to this definition risk is not a neutral concept. Risk has negative connotations within prostitution and medical discourse associated with loss. It encompasses extremes of outcomes from danger and threat to unfortunate and annoying. The term risk, therefore incorporates a multitude of outcomes.

Meanings attached to and the strategies used to manage risk are attempts to control uncertainty. For instance risk mitigation in prison literature describes measures that control (e.g. restriction of movement), manage (e.g. close monitoring of high risk offenders) and reduce (e.g. rehabilitation programmes) risk (Clear and Cadora 2001). As Lupton (2002, p.15) writes *"...it may be said that there are a series of discourses on risk that serve to organise the ways in which we perceive and deal with risk"*. In post modernity, examples of these discourses would be risk as future uncertainty and risk as probability. The former describes incalculable potential consequences particularly in relation to new technologies (e.g. mobile phone masts). The latter describes risk when the likelihood of an event occurring is based on scientific investigation and objective rational calculations.

A perspective on risk is the socio-cultural approach containing three categories, among which are the 'governmentality' theorists and 'risk society' theorists. In brief, the former theorists adopt a Foucaultian approach analysing how discourses, institutions, strategies and practices construct and select certain truths about risk. Governmentality theorists are interested in exploring *"...risk in the context of surveillance, discipline and regulation of populations"* (ibid., p.25). Answers are also sought on how the rational and calculated construction of risk dictates what is normal behaviour. In turn what is believed to be 'normal behaviour' encourages responsibility and self-regulation of the body by voluntarily following governmental advice.

In a 'risk society' (Beck 1992) the causation of new forms of risks (e.g. traffic congestion) are identified as the results of technological change within the process of industrialisation and globalisation. Rational and autonomous individuals are living in a transitional period within which the conceptualisation of risk *"...is no longer about private fears of the random unknown..."* but involves *"...public perception of universal dangerousness and threat"* (Culpitt 1999, p.4). Although individuals have more opportunities and choice, traditional family and social ties have dissolved increasing the exposure to unnatural risks. New risks are long lasting, irreparable and incalculable, *"...nuclear, chemical, genetic and ecological mega-hazards abolish...the calculus of risks"* (Beck 1992, pp.101-102). Science becomes part of the risk problem. Science and technology not only manufacture risks with uncertain or unintended outcomes but there are frequently competing scientific claims on both the extent and occurrence of risk, undermining expert opinion. Possessing power and wealth and the ability to control knowledge is paramount. Social, political and economic factors have a large impact on the distribution of risk. Poverty increases the likelihood of some risks, money enables the wealthy and well educated to deal, avoid or compensate for certain risks. However, the growth of modern risks (e.g. air pollution) which are widespread and invisible are reducing the gap between rich and poor.

Important to this thesis is the cultural/symbolic perspective within the socio-cultural approach. This approach acknowledges the social, cultural and institutional contexts within which sex workers understand risk and make decisions on that understanding i.e. the construction, the focus of this study. Theorists within the cultural/symbolic perspective primarily hold a social constructionist epistemological position. They explain the concept of risk as constructed through pre-existing knowledge and discourses within social interactions, incorporating moral beliefs and shared definitions. Of importance in this

approach are *"...the differing type of 'knowledge' which inform perceptions of risk, and ... the moral dimensions to risk and risk taking"* (Fox 1999, p.206). The meaning of risk is never static but is renegotiated being part of a specific time and place. So *"[i]f a risk is understood as a product of perception and cultural understanding, then to draw a distinction between 'real' risks (as measured and identified by 'experts') and 'false 'risks' (as perceived by members of the public) is irrelevant"* (Lupton 2002, p.33). It is the way in which risk is constructed and then acted upon which is of importance to this thesis. The varying perspectives on risk between, for instance, scientists (experts) and non-scientists (the general population) illustrate differing knowledge of the world. The meanings sex workers attach to risk have logic and rationale within their own views of and situation within everyday life. Individuals assess risk on their understanding of the probability of a risk occurring, the severity of and the proximity to the risk, the time-span involved in the undesired outcomes and their ability to cope with the risk (Douglas 1986). In situations which are familiar, individuals underestimate or ignore risks, specifically risks *"...which are supposed to be under control..."* and *"...which are rarely expected to happen"* (Ibid., p.29). Beck (2002, p.75) writes that individuals often deny or 'interpret away' risks when avoidance is impossible. This strategy can be observed in the behaviour of sex workers.

The 'cultural/symbolic' perspective advanced by Douglas in 1986 analyses how notions of risk are used by institutions and social groups to *"...establish and maintain conceptual boundaries between the self and Other..."* (Lupton 2002, p.25), in turn controlling deviance and therefore maintaining social order and stability. The 'Other', in this thesis the sex worker, is perceived as a 'pollutant', marginalised and stigmatised, a risk to the purity and integrity of the 'self'. The label 'at risk' further marginalises sex workers who have neither the financial, cultural nor social resources to make 'rational' life choices in respect to risk. Risk has become a central part of human subjectivity and existence and is *"...associated with notions of choice, responsibility and blame"* (Lupton 2002, p.25). Risk in relation to health will be discussed in the following section.

(i) Health Risk

Individuals are categorised as either risk–takers (risks can be actively sought e.g. extreme sports) or risk–avoiders (Kemshall 2002). Whatever the risk choice individuals justify it and *"...consider* [the risk choice] *as both rational and reasonable..."* (ibid., p.13). The construction of risk serves different functions depending on the extent to which an individual is believed to be able to control or avoid it. Strachan and Tallant (1997) summarise

Kahneman and Tverskys' work on risk choice in terms of 'framing'. When applied to sex workers they avoid risks to health (e.g. use condoms, clean needles) when they believe they are in 'zones of gain' as they want to remain free from harm (e.g. infection). However, when sex workers consider themselves to be in a 'zones of loss' (e.g. financially insecure, desperate for drugs) they are already doing badly so they believe they have less or even nothing to lose in taking risks which threaten their health.

Lupton (2002) identifies six major categories of risk, which dominate post modernity western philosophy and can be applied to sex workers. Of relevance to this thesis are 'lifestyle risks' (e.g. the use of drugs, the undertaking of sexual activities); 'medical risks', which are associated with the use of medical services for care or treatment, and 'interpersonal risks' that emerge from relationships (e.g. involvement in an intimate relationship, social interactions, friendship) (ibid., pp.13-14).

Nonetheless, *"[r]isk is a selective process:...some risks are ignored or downplayed while others are responded to with high anxiety, fear or anger"* (Lupton 2002, p.39). This study aims to understand this selective process, which requires knowledge of the underlying rules, conditions and authorities influencing the sex worker and service provider (i.e. the constructions). It primarily focuses on the risks associated with sex work including identification and management. The health risk for women attached to certain types of work (e.g. housework, caring) has been the focus of other research (Bernard 1973; Doyal 1999; Lloyd 1999).

The negative health impacts of being a housewife, rather than marriage itself, were the focus of Bernard's study in 1973. Although Bernard has since been criticised for her methodology particularly concentrating on a narrow definition of stress (e.g. mental disorders show themselves more as alcohol and drug abuse in men) it has been a seminal study for the last thirty years and as such is important. Bernard reported many housewives interviewed considered themselves to be happy. If housewives became ill, the medical profession assumed that this was due to their perceived inability to cope with the demands of marriage or their lack of ability to redefine who they were once married. Bernard (Ibid.) believed poor mental and emotional health was due to the 'Pygmalion effect'. This she identified as being evoked by the restrictive conditions of marriage whereby the woman conformed to her husband's wishes, needs and lifestyle, gradually 'dwindling' into a wife. The 'housewife syndrome' was the label used to explain the psychological distress suffered

by housewives and included symptoms such as a negative and passive outlook, heart palpitations, fainting, nightmares, anxiety, depression, and nervous breakdown. Bernard (ibid., p.37) wrote marriage caused such an upheaval in women's lives it should be recognised as a *"...genuine emotional health hazard(s)"*. Not all married women become ill but Bernard (ibid) identified a causal pattern between marriage and poor mental health as she herself writes *"[i]n truth, being a housewife makes women sick"* (ibid, p.48).

Later studies by Doyal (1999) and Lloyd (1999) confirm the risks to health of unpaid housework (e.g. exposure to toxic substances, isolation) and caring, particularly the 'heavy end' of caring (e.g. personal and physical care, lifting of heavy weights). Both tasks are identified as female and natural for women to undertake in the private sphere of the home. When combined with the *"...multidimensional and fragmented nature of the work itself"* (Doyal 1999, p.22) and the fact that measures of risk reflect male patterns of work (Messing 1999) housewives and carers are left unprotected in the household environment. Risks to health of unpaid work are dependent on women's economic status (e.g. level of economic security) and social or cultural beliefs incorporating level and type of social support and social contact and the degree of individual control and autonomy (Payne 1999).

Risk and concepts of work and health are all socio-culturally constructed within a historic, economic context. Risk connected to work is based on the social construction of occupational health and disease within paid formal employment in a defined visible workplace. Risk is regulated in the form of occupational health and safety legislation. Many forms of employment (e.g. construction industry) present risks to health but legislation (e.g. Health and Safety at Work Act 1974) attempts to protect the worker by reducing the risk attached to employment. Criminal legislation exists relating to prostitution but there is no legislation to protect their health or welfare whilst 'at work'. For sex workers different types of legislation, as discussed in Chapter One, lead to different types of risk which in turn lead to different types of harm. Risk within sex work is recognised by organisations such as The International Union of Sex Workers and United Kingdom Network of Sex Work Projects. However, demands for full employment rights were strengthened, albeit slightly, when in 2002 prostitution was given mainstream union recognition when an entertainment and sex workers division was set up in the GMB, Britain's fourth largest trade union. At the end of 2003 the division had 200 members (BBC News UK 2003).

Despite GMB representation sex workers working for others are left legally unprotected when they work, as risk remains defined in occupational health and safety terms. Prostitution is both unrecognised as work, as it is risk that lies outside the notion of formal, regulated work, and unregulated in terms of occupational health and safety policies. As outlined in Chapter One (e.g. II.3), a sex worker is perceived by service providers, the general public, and the police to be putting herself at physical and psychological risk when selling sex. The way in which sex workers earn money presents an occupational hazard in terms of their physical and mental health. Risks in relation to selling sex are considered by sex workers to be 'part of the job', an expected consequence similar to the risks considered to be 'part of the job' by housewives and carers. Risky behaviour that affects the health of sex workers is believed by the general public to be a consequence of lifestyle choice. For instance a sex worker who contracts a sexually transmitted infection, particularly HIV/AIDS, through the practice of risky behaviour (e.g. unsafe sex, intravenous drug) is understood to be outside 'normal', 'innocent' behaviour and sex workers are labelled as 'guilty'. So in part *'*[t]*he HIV virus itself is no longer a risk to health: the* [sex workers] *ability to control their sexual behaviour is now the risk"* (Ogden 1995, p.413). The sex worker is a risk to public health.

Lupton (1993) writes of two discourses within public health in relation to risk. The first looks at risk at an environmental level (e.g. air pollution, toxic waste) which an individual has little or no control over. The second, which is relevant to this thesis, constructs risk as the outcome of personal lifestyle choices emphasising individual self-control to avoid the damaging lifestyle. To make individuals aware of health risks, the health message for the latter discourse was relayed through the media by the medical profession (Beattie 1991). The hope was once individuals were educated about the risks posed by certain lifestyles, the identified risky behaviour would be avoided (Lupton 1993). Defining risk in this way enables public health discourse to apportion blame and hold an individual accountable when a negative outcome occurs. This is a simplistic construction of risk that disregards vulnerable populations' inability to respond to education due to the need to survive. Risks are not *"...matters of accident or fate"* but are *"...individualized and responsibilized..."* (Kemshall 2002, p.1). The risk-taking behaviours of sex workers become the cause of disease.

The public health discourse of lifestyle choices, and the accompanying public health approach can be illustrated in the targeting of sex workers for HIV/AIDS education

programmes in the late 1980's early 1990's. Sex workers were identified as at a higher risk from contracting HIV than the general population due to having multiple sexual partners and the type of sex that could be requested (e.g. non-use of condom, anal sex). In turn sex workers posed a high risk to the health of the general population. Once again as in the nineteenth and twentieth centuries sex workers were recognised within moral and medical discourses as a risk to others, 'the pollutant'.

'[A]*s risks become increasingly unknowable and incalculable, formalized systems for assessing and managing risks grow*" (Kemshall 2002. p.9). When identifying risks to health, risk assessment and risk management are key factors to be taken into account. Risk assessment entails epidemiologists calculating (e.g. by using measures of mortality and morbidity) the 'relative risk' of a selected section of the population to developing an illness when exposed to the 'risk factor', compared to a different but similar section of the population who have not been exposed to the 'risk factor' (Gabe 1995). Rational decision-making processes are then applied to find the causal variables linked to illness and disease. The outcomes of these assessments are combined with the perceived ability to quantitatively measure (i.e. in cost and benefit terms) the risks associated with different choices. In turn, risk management involves monitoring and surveillance, which, at the most basic is an attempt to control costs and to reduce risks. In relation to sex workers this involves service providers making current and relevant health care information easily accessible, offering regular sexual health checks and providing adequate amounts of free condoms, clean needles and 'Sharps bins'.

Within techno-scientific discourse is the cognitive science perspective to undertaking risky behaviour, which uses "*...various psychological models of human behaviour to identify the ways in which people respond cognitively and behaviourally to risk*" (Lupton 2002, p.19). An example of psychometric risk analysis is the Health Beliefs Model (Rosenstock et al, 1994), which examines factors that might predict health behaviour, prompt individuals to seek medical care and affect an individual's willingness to follow that advice. It adds depth to the construction of risk as the outcome of personal lifestyle choices. An individual's decision to carry out risky behaviour is seen to be the result of the perceived susceptibility and seriousness to individual health of the risk and the ability to take effective evasive action (Scambler and Scambler 1984; Kronenfeld 1988). Individuals willingly seek and carry out medical advice due to the perceived severity of the illness, the success rate and side effects of the recommended treatment. Risk avoidance is believed to be the result of

rational behaviour and action whereas risk-taking is irrational. However, this *"...assumes human responsibility and that something can be done to prevent misfortune"* (Lupton 2002, p.3). Risk assessment is carried out at an individualistic level. What needs to be borne in mind is that the perception of risk does not have an independent objective existence; symbolic meanings attached to objects and lifestyle affect judgement (Gabe 1995). Risk cannot be separated from social, cultural and institutional contexts, which in turn constrain the choice of an individual (Denscombe 1993). For instance Bloor (1995) describes the effect of peer group pressure and social interaction on drug and alcohol use.

The techno-scientific discourse addresses risk as a calculation of probability, risk is an objective fact that once measured can be mitigated against by using scientific knowledge. Debates within this perspective concentrate on for example the accuracy of the calculation, the seriousness of the outcome, conflict and distrust between the public and scientific, industrial and government institutions. The general public are believed to have inappropriate knowledge about risk and therefore respond unscientifically to risk.

In analysing sex workers' perception of risk and the undertaking of risky behaviour, acknowledgement is required of the complexity of the working environment (e.g. pressure due to fear of arrest, financial desperation, children being at home) and the multi-dimensional nature of the risks (e.g. robbery, verbal and physical violence, rape, sexually transmitted infection) encountered. Risky sexual behaviour involves at least two individuals and the sexual act may not be an act of free choice. Also a distinction has to be made between different types of sexual behaviour within different types of relationships involving non–paying partners, regular and one off paying customers. To make the distinction between work and home, some sex workers do not use condoms in their private lives, as they see no risk attached to this relationship. Due to repetition, the action becomes taken–for–granted daily behaviour so the calculation of costs and benefits are less likely to occur. The risky behaviour becomes routine and so feels safer. As Beck (2002, p.79) comments, *"...in a catastrophic society...the state of emergency threatens to become the normal state"*. In addition, intervention to reduce risk can have the unintended consequence of individuals undertaking behaviour with the same risks or increased risk due to the belief that they are 'safe'.

The analysis of sex workers' and service providers' discourse will enable an understanding of the differential construction of risk (e.g. rules, conditions, authorities) and the underlying

influences (e.g. institutions/power groups, social relations and economic processes). Lupton's (2002) categories of 'lifestyle risks', 'medical risks' and 'interpersonal risks' will support the interviews. Health risk as defined by sex workers and service providers, will be investigated by applying Bradshaw's theory of 'felt' and 'normative' need to risk. The socio-cultural risk perspective approach will be followed to determine the context (i.e. social, cultural and institutional) influencing attitude and behaviour with respect to risk. Risk in this thesis will facilitate the analysis of how sex workers 'rationally' and 'instrumentally' interpret and cope with risk within their own understanding of their social and economic world. The review of formal assessment methods has indicated this approach as too structured to facilitate gaining the underlying construction of risk within which the complexity of the work environment and the multi-dimensional nature of risks has to be acknowledged. Behaviours that would be deemed to be irrational in psychometric risk analysis can be a rational choice for the sex workers working within this environment.

This chapter has clarified the use of Foucault discourse analysis and identified the normative theories of need and risk applicable to this study, together forming 'the analytical framework'. The theoretical framework of discourses and discursive constructs identified in Chapter One, coupled with this analytical framework, forms the basis of the researcher's discursive framework, which will be used to analyse the empirical data. The following chapter describes the processes and procedures to acquire the empirical data and to implement the analytical framework, supported by the theoretical framework.

Chapter 3

METHODS & PROFILES: DETERMINING THE PROCESSES AND PROCEDURES & INTERVIEWEE INSIGHT

This chapter comprises two sections. The first section describes the methods (i.e. processes and procedures) that were followed to acquire and analyse the empirical data thereby implementing the analytical framework, supported by the theoretical framework. Acquisition and analysis of the empirical data will be undertaken to determine sex workers' and service providers' individual and group constructions of the discursive themes, identifying the conditions, rules and authorities from the interview statements that have directed them and the underlying influences. In short, the aim of the analysis is *"...to discover that whole domain of institutions, economic processes and social relations on which a discursive formation can be articulated"* (Foucault 1972, p.5). The second section provides a profile overview of the salient characteristics of the interviewees and the city supported by detailed profiles in Appendix C. It enables the reader to appreciate a little of the sex worker's life history and some professional aspects of the service provider interviewees, enabling the exploration of the origins of meanings attached to need, risk, access and provision. Additionally a description is provided of 'Old Port', where the research was conducted, thereby providing background information on the environment within which the respondents lived and worked.

I. METHODS UNDERTAKEN

This section details how access was negotiated to twenty one sex workers and ten interviewees from seven service providers. The chapter explains how undertaking a small pilot study using three questionnaires allowed an understanding of the problem domain (e.g. use of terminology) so enhancing the interview process before performing thirty recorded semi-structured interviews. Ethical issues and research dilemmas expected and encountered during the fieldwork are explained and the solutions or part solutions undertaken to resolve the dilemmas outlined. The section continues by describing the process of discourse analysis and the rules under which thematic indexing was used to analyse the data obtained via the semi-structured interviews. A common criticism of qualitative research is that it is subjective. To respond to this limitation, and reflect on the process (i.e. reflexive approach) I have been disciplined in my method documentation and

in this chapter I make my subjective approach overt by providing a detailed account of the processes and procedures followed. To this effect some sections are written in the past tense based on what actually happened, whilst others are written in the present tense to define the procedure to be followed. The following sections describe data acquisition, initially how and why access was negotiated through gatekeepers for sex worker interviews.

1. ACCESSING THE 'DIFFICULT TO ACCESS'

To enable the identification of health projects that are used by sex workers, thus enabling contact with interviewees, I attended two EUROPAP UK meetings. EUROPAP is the European Network for HIV/STI Prevention in Prostitution, which in 2002 was superseded in the United Kingdom by The UK Network of Sex Work Projects (UKNSWP). Details of the meetings were obtained from the EUROPAP UK co-ordinator who granted me access. Contact with the service providers was initially made, with the PhD thesis in mind, to obtain data for a qualitative thesis while reading for a Masters in Social Research, a requirement for first year PhD students (Leaney 2000). Approximately twenty service providers were present at the EUROPAP meetings representing voluntary organisations from across the country and ranging from drug projects, sexual health outreach to counselling. This provided a wide range of clinical practice, experience and differing views on the most appropriate way for voluntary and statutory projects to work with sex workers.

At each meeting I introduced myself to service providers. After listening to presentations on their projects, it became apparent that of the twenty representatives present at the meetings approximately a third used the social care model in their work with sex workers. These meetings allowed the identification of projects to be evaluated for suitability as gatekeepers. The projects following the social care model met the outline of my criteria; they (i) dealt with a multitude of needs and risks, (ii) had contact with sex workers through out-reach and drop-in (iii) worked with street and parlour sex workers. Of these service providers, two projects were accompanied by sex workers who used the service, thus suggesting that not only did sex workers have the opportunity for input within the project but the service providers wanted them to be involved with discussions relating to the most appropriate way to work with sex workers countrywide. At the meeting the service providers from these sexual health outreach projects indicated they were interested in taking part in the research.

(i) Negotiating With Gatekeepers

Gatekeepers, such as drug and sexual health outreach workers, had been a successful way to recruit interviewees in previous research (Taylor 1993; Phoenix 1999; Goode 2000). As such after the EUROPAP meetings I began negotiating access to sex workers through the service providers from the two selected sexual health outreach projects. Service providers were used as gatekeepers due to the nature of prostitution; it is a vulnerable, hidden population in a very closed community. Schensul et al (1999, p.130) define the features of a hidden population as not only *"...populations that are comparatively difficult to find and recruit into a research project"* but also as a *"...population whose boundaries, characteristics, and distribution are not known"*. As with any hidden population time has to be spent building a relationship with the individuals, also, when working, sex workers want to get on with their own business, that of earning money. For the sex workers to accept me, an unknown outsider, would have been difficult and time consuming without the gatekeepers with whom they already have a trusting relationship.

After an introductory letter and at a meeting with the 'inner city' service provider, and via a letter and telephone conversation with the service provider in 'Old Port', each service provider was made formally aware of the aims and objectives of the research, the requirements of and their expected role as gatekeepers. It is at this point that 'conditional access' can be granted (Lee 1993). In these cases the gatekeeper allows access to research respondents but imposes conditions on the access. Conditions include gatekeeper input on the choice of methodology used, the researcher having to undertake a separate piece of research for the gatekeeper and *"...the right of the gatekeeper to examine, modify or censor published material arising from the study"* (Lee 1993, p.125). Conditional access illustrates the power of gatekeepers. Hammersley and Atkinson (1995) among others write that gatekeepers not only place conditions on access but can deny access to the research population. Several weeks after the initial meeting I found out how crucial gatekeepers were to the research process. The management committee of the 'inner city' project declined to act as gatekeepers, thus denying me access to their clients. The reasons given for their refusal were the perceived time commitments for their staff that they believed my research would require, low staffing levels and the fact that research had been carried out at the project the year before my planned research. The refusal was despite very positive feedback from the service provider before the committee meeting when the decision was made. The negotiating process with the 'inner city' project had taken two months and resulted in failed access.

However, the 'Old Port' sexual health outreach workers, after telephone calls to discuss any queries, agreed to act as gatekeepers with no access conditions. A date was set for me to visit the project. I discussed with the sexual health outreach workers my criteria for the interviewees, as I wanted to interview a cross section of sex workers whom the sexual health outreach workers supported. I stipulated that sex workers should (i) have differing experiences of sex work (e.g. just started working, been working for a long time or not working at the time of the interview), (ii) be working from any location (e.g. from the street, off street), (iii) be selling any kind of sexual service (e.g. penetrative sex, hand relief, domination) (iv) be capable of participating in the interview (i.e. not under the immediate influence of drugs) and (v) be over eighteen years of age. As can be seen in the profiles section of the chapter, sex workers chosen by the sexual health outreach workers had varied health needs, worked in a variety of environments with different risks attached to their prostituting and used a multitude of health care services.

The sexual health outreach workers managed the interviewee selection process. They initially asked sex workers if they wanted to take part in the research, and those who agreed were placed on a list. When the time came to carry out the interviews the sex workers were approached again to ascertain if they still wanted to participate. For those who agreed to take part in the research I made available, via the sexual health outreach workers, a letter introducing the research and myself. This included my mobile phone number. The number was in case any of the sex workers wanted to discuss concerns before agreeing to take part in the interviews although this offer was not taken up. My aim was to conduct three pilot questionnaires and twenty semi-structured interviews. Despite the sexual health outreach workers' initial pessimism due to the chaotic lifestyle of sex workers, they agreed to try and get as close as possible to the required number meeting the research criteria.

As Fountain (1993, p.150) acknowledges, using different gatekeepers to those she had chosen would have resulted in her research targeting a *"...different group of people within a different culture"*. This was true in this research as sex workers who agreed to an interview were those who not only had contact with the gatekeeper, but were a selection of sex workers chosen by the gatekeeper out of the total population who sought help and advice. It is accepted the type and extent of influence the gatekeeper may have on the interviewee selection is unknown (e.g. favouritism). The gatekeepers made me aware that sex workers who agreed to be interviewed were only a proportion of sex workers they came into contact

with (i.e. 80 to 90 in the three month period when the research was conducted), who in turn were only a proportion of those prostituting within the city particularly those working off street although the true population size was unknown. Further, sex workers who used the sexual health outreach project had obvious concerns relating to prostitution and their health or they would not use the service. It has to be borne in mind that sex workers who had little or no contact with the sexual health outreach workers may construct their health needs and health risks differently and in turn use different health care services. Thus, as the study explores perceptions and subjective constructions the resultant knowledge gained relates solely to the sex workers interviewed dependent of their individual life and work histories within the context of 'Old Port'.

The next section provides the process of obtaining access to the service providers to be interviewed.

2. ACCESSING THE SERVICE PROVIDER

Non–probabilistic, purposive and snowballing sampling were used to gain access to the service providers. Purposive sampling was used to obtain the initial five contacts as it enabled me to *"...seek out groups, settings and individuals where...the processes being studied are most likely to occur"* (Denzin and Lincoln 1994, p.202). Projects and clinics within the sample population were therefore intentionally identified and chosen due to their research relevancy (Sarantakos 1993). They were relevant because they (i) specifically worked with sex workers or (ii) worked with sex workers and non-sex workers or (iii) specialised in health care or (iv) were among the service provision mentioned by sex workers during their interviews. The latter criterion dictates that the service provider access process is performed after the sex worker interviews. Two of these initial contacts were identified from the EUROPAP meetings; the remaining three were those mentioned during the undertaking of the pilot study questionnaires. Snowballing was then employed to gain names of relevant workers within other projects/clinics. A total of ten possible interviewees from seven different service providers following a mix of biomedical and social care models were identified.

To negotiate access I contacted the service provider by phone, explained the aims and objectives of the research and arranged a convenient time for the interview(s) to take place. All of those contacted agreed. Only one service provider, a psychiatrist, requested formal identification from my supervisor in the form of a letter on university headed notepaper. The

psychiatrist was the most qualified interviewee and worked within a highly structured, traditional framework, which I presume is why authoritarian proof of both the research and researcher legitimacy was required.

3. ACQUIRING THE EMPIRICAL DATA

The following section explains the methods of data acquisition including the pilot study and the semi-structured interviews. A common aspect, interview location is identified at the end of this section.

(i) Pilot Study: Exploratory Questionnaires

Researching any population requires a degree of understanding of their lifestyle, acceptance and discretion. Interviewing a vulnerable population and in addition asking detailed personal questions relating to sex was a difficult task, requiring specific techniques and knowledge. To obtain these and thus ensuring the main interviews with the sex workers were effective, 'safe' and did not cause offence required an exploratory pilot study. The aims of the study were (i) to understand the limitations of the interview environment (ii) to appreciate sex workers working and living environment (iii) to accept sex workers attitude and responses, and realise mine to the interviews (iv) to develop the correct interview technique to use with the sex workers, (v) to develop the relationship with the gatekeeper, limiting personality effects (vi) to enable key issues to be identified for further investigation when undertaking the interviews and (vii) for different terminology used by sex workers to be recognised and clarified.

A pilot study was not carried out with the service providers before their interviews as service providers had been interviewed for my MSc, so terminology had been clarified, the research field was familiar and the interview dynamic established.

The pilot study was implemented as an administered questionnaire. This method allowed all the required criteria to be addressed but sometimes hidden within questions, and the reactions monitored. As such the questionnaire was designed having sections relating to health need, ill health, health care provision and access to health care (see Appendix A). I considered a minimum of three questionnaires would provide a basic cross-sectional sample (e.g. parlour and street working sex workers).

A mixture of question types was used in the questionnaire. 'Close ended' questions with multiple choices allowed the interviewees to consider the range of options relating to the study and provided a mental prompt and increased the sex workers' confidence in the interview process. There was a risk here of introducing misleading researcher bias by providing choices, but the questions were not fully closed, the option 'other' was included. 'Open ended' questions were used to allow greater freedom of expression, and allowed the interviewees to qualify answers in their terminology. The questions were ordered so that easy to answer questions were first, to build confidence of and relax the interviewees. A self-administered questionnaire was not carried out due to the high probability of the sex workers low educational attainment and their limited concentration. Their chaotic lifestyles would leave no time for completing the questionnaires if left with them. An administered questionnaire provided the opportunity and the scope to clarify answers and for sex workers to add information.

The questionnaires were aimed to be of approximately 45 minutes duration, long enough to build a relationship and get detail but not too long that the sex worker would tire or become bored, especially taking into account the nature of the questions. This also helped in understanding their attention span and the implication on the interview durations. The questions were worded in a clear, concise, uncomplicated format. The questionnaire was critiqued and tested on several non-sex workers and updated before being used in the field. On discussion with the gatekeeper a date was set for me to travel to Old Port to carry out three questionnaires with sex workers selected from the interview list. The gatekeeper identified and re-confirmed with five sex workers their agreement to participate. Five sex workers were short-listed due to reliability concerns expressed by the gatekeeper.

The questionnaire responses were manually analysed to identify sets of data and lessons learned relating to the criteria themes used during the semi-structured interview design and interview process.

Fulfilling the aims also ensured rapport and trust was built and continued while carrying out the interviews. Nonetheless it was a continual process, which for instance was easily lost by an inappropriate action or response. *"Rapport is tantamount to trust, and trust is the foundation for acquiring the fullest, most accurate disclosure a respondent is able to make"* (Glesne and Peshkin 1992, p.79 cited in O'Connell et al 1994, p.122).

(a) Reflections: Ensuring Rapport

"Only by maintaining a receptive, permissive and non-judgemental attitude throughout" can the interviewer gain and maintain rapport (Oppenheim 2001, p.73). My interview technique adhered to Oppenheims (ibid) guidance resulting in the sex workers being at ease, clarifying and using their own terminology. For instance in much of the contemporary literature the term 'sex worker' is used but sex workers use the terms 'working women' or 'women who work'. Therefore 'working women' was used in the interviews to address sex workers. As I administered the questionnaire and included open-ended questions the sex workers were able to participate more fully in the process, putting forward additional areas for enquiry. This process gave me an insight into 'how matter of fact' the sex workers were regarding harrowing details of their lives and how they survived these traumas. I was surprised by how difficult I found asking sensitive questions partially based on my perception of a vulnerable population, and the realisation of the completely different worlds we lived in.

Rapport was further ensured by being aware of and working around the constraints that sex workers lifestyles imparted on their ability to commit to pre-arranged appointments. Time spent attempting to meet up with sex workers confirmed the difficulties involved with accessing and interviewing a vulnerable population. Out of the five sex workers who had originally 'loosely' agreed to complete the questionnaire, one was not at home at the arranged time, one was working as she had not made enough money the night before and another had been so busy working the night before she was too tired to come to the project. While I undertook the two questionnaires with Fiona and Gillian at the sexual health outreach project the gatekeeper contacted other sex workers on the interview list until they found a third interviewee, Ebony. Although I was expecting problems with non-turn-up, the day spent doing the questionnaires made me very aware of the chaotic lifestyle of some sex workers and the difficulties of gaining access to twenty within the time span without the support of a gatekeeper.

(b) Reflections: Building Trust

Sex workers knew enough about me (i.e. mainly that the gatekeepers trusted me) to enable them in turn to trust me and agree to take part in the interview. The sex workers knew from experience that the gatekeepers would not put them in any situation that would harm them. As Taylor (1993) found when researching injecting drug users, being accepted and therefore trusted was not a difficult process. However, I had to build on the initial trust by

being aware of both my obligation to ensure anonymity and confidentiality and the fragile nature of trust. Trust could easily be destroyed as illustrated by my first interviewee, Fiona, when she accused me of 'seeking discreditable information' (Lee 1993). Fiona broadly categorised my research with popular discourse, which she believed constructed sex workers as 'dirty old slappers'. By further discussion of the research objectives she became less defensive and more positively involved. The lesson I learnt was not to take it for granted that the interviewees fully understood the nature of the research. The objectives were explained at the beginning and on completion of the questionnaire.

My initial concerns of being seen as an outsider in their environment and so untrustworthy, resulting in sex workers not being frank and forthright, quickly diminished as sex workers openly talked about their health. In fact they were surprisingly open. By building on the initial trust sex workers felt towards me (e.g. ensuring anonymity and confidentiality), it became clear that key issues for the three sex workers regarding health need and health risk were drugs, poor mental health, violence and sexually transmitted infections. It also became apparent that although the sex workers worked in different places they were extremely knowledgeable on health care services that were available, particularly Ebony and Gillian who used drugs. This introduction to the research field enabled the interview questions to use appropriate language, make a more clear distinction between need and risk (i.e. the criteria), to appreciate the differences (i.e. street versus off street workers, drug users versus non-drug users) and similarities of sex workers (e.g. the need to earn money). The questionnaires enabled greater clarity of the research themes, environment and the sex worker lifestyle to be obtained.

The pilot study confirmed my preliminary view that semi-structured interviews were the correct method to acquire the data. Once the results of questionnaires were available the interview process commenced with sex workers followed by service providers.

(ii) Main Study: Semi-Structured Interviews

(a) Uncovering Meanings

I needed to uncover the meanings sex workers and service providers attach to 'health need and' 'health risks' and the underlying influences that had directed their construction while working to the frameworks identified in Chapters One and Two. Semi-structured interviews provided the opportunities to do this. As Rubin et al (1995, p.8) state, *"[q]ualitative interviewing explores the shared meanings that people develop..."*. Interviewers look for

"...the taken-for-granted assumptions of the interviewees and try hard to understand the experiences that have shaped these assumptions" (ibid., p.9). Sex workers and service providers influenced the research, as the method was interpretative and flexible. Interviewees developed and qualified their ideas and clarification was sought. The rapport built between the interviewer and interviewee was invaluable when discussing sensitive and painful issues or experiences. Semi–structured interviews enabled the possibility of viewpoints and issues to be raised that I was not aware of or considered as important. The interviews enabled priority to be given to the views expressed by the sex workers, as they had both the health needs and experiences that either facilitated their use of health care provision, or prevented access.

Brannen (1988) (as opposed to e.g. Oakley 1981) emphasises the merits of a one-off interview when seeking answers to sensitive issues. The interviewer is a stranger and therefore *"socially remote"* from the interviewee (Lee 1993, p.113). With little chance of the interviewee and interviewer meeting after the interview, the interviewee is more open.

(b) Interview Design

It was apparent from undertaking the pilot study with sex workers that an interview duration of sixty minutes enabled an in-depth discussion and was the limit for them to cope with (e.g. because of their inability to concentrate due to drug addiction or mental health damage). The MSc semi-structured interviews with the service providers also indicated that this duration was feasible to obtain the necessary data allowing the service providers to plan for other responsibilities (e.g. lack of time due to other appointments, dealing with client emergencies).

As with the pilot study, clear concise uncomplicated wording was used for the interview questions. The interview began with an explanation of the research aims and objectives and core questions relating to the sex workers work history (e.g. age, place of work, length of time working etc.) or the service providers' employment, project or clinic history. These core questions allowed comparison and identified differences enabling cross-case analysis. As the pilot study questionnaire structure provided a good basis for discussion of the themes, the interview schedule contained similar sections. Although the order changed depending upon the responses from the interviewee and their need to talk about specific experiences, the questions were loosely adhered to, to enable comparisons. An interview

schedule was used to make the semi-structured approach easier, upon which notes to guide the interview and to support the digital sound recording were written.

The number of interviewees, twenty one sex workers and ten interviewees from seven service providers, was of a manageable size for the methods used and timescales involved. This was a similar sample size to previous qualitative academic prostitution research undertaken (e.g. Phoenix (1999) 21 interviewees; Hoigard & Finstad (1992) 26 interviewees). As with the pilot study the gatekeepers organised and managed the sex worker interviews. I dealt directly with the service providers to be interviewed.

(c) Interview Process - Experiences

I pre-arranged with the gatekeepers when I would travel to 'Old Port' to carry out the interviews. The dates were left very much to the gatekeepers to decide as I was heavily reliant on the gatekeepers to negotiate with the sex workers, transport them and deal with any problems that arose during or after the interviews had taken place. I stayed in 'Old Port' on three occasions ranging from one to three nights. As was found while carrying out the questionnaires, sex workers missing appointment times was a problem. On one day despite three being arranged only one interview was possible. This illustrates the problem was not in making appointments but for the sex workers to keep them. It is easy to agree to be interviewed when the interview is in a few weeks time but when the time actually arrives uncertainties arise and lifestyle gets in the way. Thus I was flexible with my interview appointments, (i.e. prepared to work within the constraints of the research environment), although this lead to carrying out five interviews in one day. This was too many but if I had turned down the possibility of an interview there was no guarantee that the sex worker would keep the next appointment. I believe the sex workers participated in the interviews for several reasons (i) I was not perceived as a professional, (ii) they could choose the time and place (iii) anonymity was assured (iv) it did not involve bad news and was on a one to one basis (v) as a favour to the Sexual Health Outreach Workers.

When interviewing the service providers I agreed the time and location and travelled to 'Old Port' for each interview arranging between one to three interviews for each trip. These all occurred at the pre-arranged time without any difficulty.

i. Different Research Populations

Interviewing two different research populations required negotiating the relationships in very different ways (Hammersley and Atkinson 1995). Not wanting to intimidate sex workers I introduced myself as a student and dressed in a very casual way. However, I introduced myself to the service providers as a PhD student with experience as a Senior Staff Nurse and dressed formally. Adams (2000) writes how the type of research respondent dictated her dress sense, 'dressing up' for police officers and criminal defence solicitors or 'dressing down' for interviews with suspects. However, where she differs from my experiences is on 'dressing up' she felt she presented *"...an 'unreal' or 'false' self..."* (ibid., p.391). I felt comfortable undertaking interviews in both dress codes presenting my 'true' self' on each occasion. In fact I would have felt more uncomfortable if I had not adhered to the two separate dress codes for the two different populations. I did not want to be perceived as 'a professional busy body' by sex workers or as 'unprofessional' by the service providers.

The interview dynamic contrasted strongly between the two research populations. Interviews with sex workers involved a heightened awareness on my part of their ability to cope with the interview process and their possible inability to stop the interview themselves (i.e. not wanting to cause offence). Out of the three interviews which were stopped, only one sex worker initiated the ending, but the remaining two were visibly relieved when the interviews were stopped. The interviews were terminated as the sex worker was either too tired to continue, too agitated possibly due to the need for drugs or they could not concentrate for long periods of time. I made them aware that the tape recorder was being turned off. So for five sex workers the length of the interviews was dependent on their physical state or their mental health needs not on the amount of data I had gained. The sex worker interviews lasted for between twenty and ninety minutes. As such I gauged how long the interview would last from the initial questions so that I gained the most appropriate data to answer the research aim and objectives. The interviews with service providers generally lasted for approximately sixty minutes and came to a natural conclusion. The service providers did not require emotional support during the interview. With consent each interview was recorded. There was one exception, a service provider who would not give a reason for not wanting to be recorded.

I will now go on to describe the common aspects of the main and pilot study, firstly where the interviews took place and some of the issues that arose in the different environments, then payment for sex workers interview time.

(iii) Interview Location

My preference was to interview the sex workers in a neutral, 'safe' location with no interruptions (i.e. the Sexual Health Outreach Project building) but I understood I needed to be flexible to gain the data. So as with previous research carried out with vulnerable, hidden populations the interviews were carried out in numerous settings (e.g. Warr et al 1999 conducted interviews in a café or a local welfare agency; De Graaf et al 1995 undertook interviews at the women's workplace or their home). The sex workers chose the setting that was familiar and comfortable or convenient due to work commitments. Interview locations included the sexual health outreach project building (i.e. 60% in an interview room), parlours (i.e. 25% in a bedroom or lounge), flats (i.e. 5% in a bedroom) and sex workers' own homes (i.e. 10% in the lounge). For the interviews at the sexual health outreach project the gatekeepers provided soft drinks, fruit and biscuits. Interviewing away from the street provided a quiet 'safe' environment for both the sex worker and me, discretion and anonymity were maintained, and police or client intervention was prevented. The interviews carried out at the sexual health outreach project were uninterrupted. During the interviews at the parlours and private flats, sex workers saw me between seeing clients. If the parlour became busy the client was either asked to come back in twenty minutes or the interview was stopped. One interview was halted three times for the interviewee to see three clients, making the information obtained disjointed but illustrating the work environment well. The duration of this particular interview was three hours. When the phone rang it was always answered and the interview halted until the call had finished. Despite my initial preference for locating the interviews at the Sexual Health Outreach Project building the 40% performed at other locations gave both adequate data and a brief insight into their work environment.

Interviews occurring in different locations with at times an unpredictable population raised safety issues around the possibility of verbal and physical abuse. As well as being responsible to the researched (i.e. ensuring anonymity, informed consent, leaving the research field as I had found it) I was responsible for my own safety. I made precautions to protect myself against abuse from sex worker interviewees, other sex workers, clients and the boyfriends, partners or husbands of the sex workers. The gatekeepers were fully aware of the dangerous situations, which could occur when dealing with at times, a chaotic population. Each interview room in the sexual health outreach project had an alarm button by the door, which was within reach if a dangerous situation occurred, additionally one of the gatekeepers remained in the building during the interviews. When interviews were carried out in other settings (i.e. parlours, flats, sex workers' own homes) the gatekeeper

and I signed out of the building where the sexual health outreach project was based. This provided the receptionists with the time we left, the location of the interview and the expected length of the appointment. If the receptionist became concerned about the length of time the gatekeeper was absent they would contact the gatekeeper via their mobile phone. The gatekeeper either stayed in the room where the interview was conducted or in an adjoining room. If clients were present the sex workers ensured I was in a separate room, usually the private office. I made sure my mobile was on, pre-programmed with the gatekeeper's and the sexual health outreach project's telephone numbers and within my reach. I have been in circumstances that could have been a threat to my safety during my nursing career and although I am aware that each is different I have always been able to calm the situation. Interestingly the sex workers who appeared to have the more chaotic lifestyles, so could be perceived to present an increased risk to either their own or my safety by their actions or more probably by the actions of those around them, all attended the sexual health outreach building for their interviews which provided a 'safe', secure environment. I felt 'safe' at all times and made to feel very welcome in all the locations whether in the interviewee's own home or place of work.

I had no concerns regarding the service providers' interview location. All interviews at their request were carried out at their place of work. The majority of the service providers had made arrangements not to be disturbed for the duration of the interview and the interviews were conducted away from the main area of work. However, two of the interviews lacked continuity, as the service providers were unable to disconnect themselves from the work place and were called away by other members of staff to sort out client problems and answer queries.

The following section discusses the ethical issues and research dilemmas that were considered and raised during the research.

4. ETHICAL ISSUES AND RESEARCH DILEMMAS

This section identifies the approaches taken to issues such as anonymity, informed consent, the researcher's responsibility to the researched, payment for interviews and the influence of 'others' during interviews.

(i) Anonymity And Informed Consent

The most important obligation of the researcher is to protect the people they study (Sobo and De Munck 1998). Guillemin and Gillam (2004) refer to ethical issues that arise in doing actual research in the field as 'ethics in practice'. Professional codes of ethics or conduct are questioned for their relevancy and restrictiveness in the research field (Norris 1993). Despite the criticisms, this research adheres to and uses the British Sociological Association (2002) statement of ethical practice, as the research had the potential to uncover what Reiner (2000, p.218) refers to as *"...dangerous knowledge"*. Knowledge which has the ability to cause harm (e.g. reputation, violence) if the respondents identity becomes known. Alongside the statement of ethical practice *"...a process of critical reflection..."* on *"...how* [that] *knowledge is generated"* (Guillemin and Gillam 2004, p.274) was undertaken, enabling a sensitive and proactive approach to *"...ethically important moments..."* (ibid., p.276).

Due to the illegality of soliciting, negative moral assumptions attached to prostitution and the sensitivity of some of the health issues discussed (see Wellings et al 1994), confidentiality was maintained at all times. The sex workers were informed that if concern for a child's safety arose (i.e. child protection issues) during the interviews I would inform the gatekeeper, as I had agreed to follow the gatekeeper's policies and procedures concerning confidentiality, best practice and child protection. I was also adhering to the Statement of Ethical Practice for the British Sociological Association (2002, clauses 30, 37). The gatekeepers would then talk to the sex worker and if they thought it appropriate would have a duty of care, as a service provider, under The Children's Act (1989, 2004) to contact Social Services. Four sex workers perceived the research as a threat to their anonymity due to their concern that information about their prostituting would be revealed resulting in stigmatisation and incrimination by those who knew them (see Sharpe 2000). After I re-iterated my ethical obligation as a researcher that within the research their identity would be known only to me and so hidden from family and friends, they relaxed. Pseudonyms were therefore used, a common precedence in prostitution research and as advised in the BSA statement of ethical practice.

As the city is anonymous in the research it was agreed with each service provider that their job title would be used. The use of a job title provides an implied degree of knowledge of the qualification of the interviewee (e.g. doctor, nurse) and the type of service they offer (e.g. drug advice, drug prescribing, sexual health advice), although these assertions are

qualified and supported by interview questions. I went as far as not identifying the city where the research was carried out as those working with sex workers consist of a very small community and at the time of the research the number of outreach projects working with sex workers was small. If the city was identified then ultimately the identity of the project, service providers and sex workers would be revealed.

Informed consent is a complex issue. As Norris (1993, p.128) writes *"...the principle of informed consent implies that two major conditions are met; first, that the research subjects are made aware of and understand the nature and purpose of the research; second, that, from a position of knowledge, they can freely give their consent to participating in the research".* Nonetheless it is difficult for an interviewee to fully appreciate what they are giving informed consent to. Is it to take part in the interview and answer any question asked of them, for both verbal and non verbal data to be used, for the data generated to be interpreted or the analysed product to be published? (Mason 2002). The consent given at the beginning of the interview may not be informed consent as the interviewee is not fully aware of the information that is going to be discussed during the interview. As such, consent may have to be re-negotiated as the interview progresses. In fact as Mason (2002, p.82) states *'[i]t may be impossible to receive a consent which is fully informed".*

Reflexive research practice was undertaken in this research to ensure sufficient information was given to the interviewees before, during and after the interviews to facilitate as far as possible consent, which was informed. I made the gatekeepers aware of the two criteria in relation to informed consent on choosing the sex workers for me to interview. The first requirement was sex workers had to be over eighteen years of age as children were not part of this research. There are difficulties in obtaining consent to interview children and ensuring that children had given informed consent to be interviewed (e.g. ensuring children's understanding of their research rights taking into account their emotional and social vulnerability) (see Ridge 2002). Child prostitution introduces different issues which are not part of the research aim (see Melrose et al 1999).

The complexity in obtaining informed consent is illustrated in this research within the context of drug use and as such the second requirement given to the gatekeepers when choosing interviewees was they had to be capable of participating in the interview. Capable in this context means not under the immediate influence of drugs. I requested sex workers who the service provider thought might not take drugs prior to an interview, as drugs have

the ability to change the behaviour of the user. Although level of drug use is very difficult for the service provider to predict I did not feel sex workers could give informed consent to the interview and fully appreciate what they were being asked, or what they themselves were saying, if under the influence of drugs. Despite this aim, Ebony who had taken part in the questionnaire, during which she had been articulate and fully in control, had used heroin just before starting the interview. The extent of her drug use was not initially obvious, she just appeared tired (as many of the sex workers interviewed were). However, as the interview progressed Ebony became more forgetful, had difficulty remembering the questions and became very vulnerable. Her drug use completely changed the interview dynamics and due to her emotional state I stopped the interview. Conversely Goode (2000), found psychoactive substances did not noticeably affect the ability of her interviewees to be coherently involved in the narrative. This episode illustrates that at the beginning of the interview when informed consent is given it is difficult for the interviewee to realise how the interview will affect them and what they will reveal. It also reconfirmed my decision that sex workers chosen for the interviews should not be under the direct influence of drugs, or as much as this is possible to gauge on first meeting them.

I made all interviewees aware of their right to refuse to be interviewed at the beginning of the interviews and to stop at any time. However, a complexity of informed consent is that although I asked for consent and they gave it I was also aware the sex workers could be doing the interview as a favour or obligation to the gatekeepers. On completion of each interview to ensure informed consent I asked the interviewee if they had any more information to add or wanted to change any of their answers, if they were happy for me to keep the interview recording.

(a) Researcher's Responsibility To The Researched

Pearson (1993, p.xvii) discusses the problem of remaining 'true' to the fieldwork *'*[t]*here is* [also] *the requirement to carry the narrative 'back home', refashioning the fieldwork experience in a textual form...".* I had to disconnect myself from the emotional trauma of the stories. Enough of the detail had to be reported to support the analysis but not too much detail so the point being made was overwhelmed. The questionnaires made me more aware of, and prepared me for the in-depth details I would hear during the interviews. If sex workers became upset and the interview was stopped the conversation was gradually brought round to discussing neutral topics (e.g. present day news items, local events). This approach responds to the Statement of Ethical Practice for the British Sociological

Association (2002, p.4, clause 28) which states *'[m]embers should consider carefully the possibility that the research experience may be a disturbing one and should attempt, where necessary, to find ways to minimise or alleviate any distress caused to those participating in research".* This approach worked very well, almost immediately the previous topic was forgotten or pushed to the back of their minds. The gatekeepers either followed up sex workers immediately or for the less vulnerable contacted them in the days following the interviews to ensure any issues were addressed.

Taylor (1993) writes of the emotional difficulty coping with certain information found out during the fieldwork. In this research, time spent interviewing sex workers identified their vulnerability and the traumatic stories they had to tell. The difficulty in dealing with the information told was not only in the detail of the stories but that the traumatic stories were told in a very matter of fact way (Brannen 1988). It took time to fully understand why and how sex workers prioritised and made sense of events. This was in part due to psychiatric treatment they had received ranging from counselling to in-patient care in psychiatric hospitals. Sex workers had learnt to internalise their emotions and had developed defence mechanisms to cope with what had happened to them. Thus they were used to talking about their health needs and health risks and rationalised painful events and treated painful experiences like every day occurrences. For instance one sex worker, Belinda, apologised for explaining how she had been sick after trying to smoke a cigarette, but had just finished describing a violent sexual attack. In addition, of the eight sex workers who had been raped seven of them talked calmly about the rape but three could not talk about their children who had been taken into local authority care. The gatekeeper warned of this issue before the interviews commenced. Children and childcare are potentially an important issue for the sex workers in respect to their mental health (i.e. self-worth) but I had made an ethical and research criteria decision not to follow it up. With respect to this thesis I believe that this issue is only one of many issues of sex workers construction of need, risk, access and provision. I felt that these issues could not be properly examined within this thesis and were so important they required a separate study within which time could be spent on the issues raised, points could be fully investigated and support given.

'Ethics in practice' occurred in different situations within the research environment. One dilemma arose when I was party to conversations and telephone conversations outside of the interview environment. Some of the data would have added to the research but was not vital. Information gained in this informal environment was not included, as informed consent

had not been obtained from the individuals involved in the discussions. In addition due to my previous occupation as a Registered General Nurse I have a specific level of medical knowledge and experience, so understand the harm sex workers could do to their health if they did not seek medical advice or intervention for a health need. I was a sympathetic listener and advised the sex workers if they were concerned about their sexual health that they speak to the gatekeeper or with their consent I would ask the gatekeeper to contact them. Sex workers had pressing, intertwined needs and complex relationships with more than one service provider. I felt I was not in the position to give or contradict advice given to them especially as I had no independent medical records about previous advice or treatment given.

An interview was conducted in a flat just off the red light district because the sex worker did not want to draw attention to herself by being interviewed in the car. She was afraid other sex workers would be suspicious and think she was talking to the police and thus alienate her from the sex worker community. I had to run in, and then run out of the flat after finishing the interview, when another sex worker told me the 'coast was clear'. This re-enforced the risk that some women were prepared to take in talking to me, re-enforcing my ethical role to leave the research environment as I had found it.

At the planning stage of the research I had made the decision to pay sex workers for their time. The money was obtained from the ESRC Research Training Support Grant, additional funding allocated by the ESRC used in this instance for fieldwork. The service providers undertook the interview during work hours and as such were salaried so no additional payment was necessary. The next section explains my rationale behind this decision and how payment was made.

(ii) Re-imbursement For Time

As an incentive to take part in research many sex workers are given advice leaflets, condoms and sterile injecting equipment, as the researchers are part of a project or clinic (see McKeganey et al 1992; Day et al and the Praed Street Clinic 1988). Davies (2000) when conducting prison-based interviews with offenders used cigarettes and lighters as an inducement for interviewees to take part in the interviews. She saw this as part of the "*research bargain*" (ibid., p.87). Although reference to direct payments given to interviewees is made in research carried out in The Netherlands (De Graaf et al 1995), America (Dalla 2002) and New Zealand (Plumridge 2001) and researchers mention the 'pros and cons'

(e.g. Davies 2000) of giving money to interviewees, the issue of direct payment is not developed in academic literature.

De Graaf et al (1995, p.38) felt that paying sex workers to take part in their interviews did not influence *"...the representativeness of the sample".* This is counterbalanced by other researchers who believe an ethical issue is raised by making direct payment to sex workers; 'paying for their time' is considered to be no different from the way in which 'clients pay for their time'. The approach I took was that the sex workers would be unaware that payment was involved when they were asked to take part in the research. I offered them a sealed envelope after the interview had finished which contained money, a token 'thank you'. So there was no financial incentive for the sex workers to become involved. In my viewpoint I am offering money for a different use of their time, it is no different to the financial recompense that individuals receive for their time and experience in any other job, the compensation is for intellectual knowledge/knowledge transfer. The positives far outweigh the negatives. The decision to pay sex workers was made on the assumption that if they were not taking part in the interview they would be earning money prostituting. By spending time with me they were losing money, which many were desperate for. I decided against a voucher due to the huge choice of vouchers available and the high probability that I would choose a shop they would never use or want to use. I did not want them losing money by selling the voucher on the street for a reduced amount. In giving money there was a high chance that this would go towards drugs or alcohol but I felt that it was their decision to make and I could not dictate what they could spend the money on. The little bit of feedback that I did get was that it went on food and cigarettes.

In addition as the gatekeeper did not tell the sex workers they would receive payment this reduced the sex workers from harassing the gatekeepers to choose them, or explain why they had not chosen them. The gatekeepers denied knowing payment was going to be made. I did not want to be the cause of resentment between the sex workers and the gatekeepers and between sex workers who had been chosen and those who had not.

Some of the sex workers gratefully received the money. It became apparent during the interviews by their attitude and responses that only three of the twenty one sex workers showed interest in the research. They were taking part in it because the gatekeepers had asked them to and they felt they owed something to the gatekeepers. The context of prostitution may well have changed the payment dynamic. I wanted the money to be seen

as a token 'thank you' for their time. Five of the sex workers saw the interviews as doing a favour for a friend (i.e. the gatekeeper) and did not want this exchange (i.e. the interview) to be seen as money for favours as it was in their working lives. I gave the money that two sex workers had refused to the gatekeepers to buy something for the proposed drop in centre. If I gave payment for interviews again I would ensure that if the interviewee appeared to be unsettled on taking the money they could donate it for instance to a project or charity as I felt I had unintentionally caused offence.

(iii) The Influence Of 'Others' During The Interviews

Although the research preference was for one-to-one interviews there were situations when this was not possible. Dee and Polly's interviews were conducted in their homes, the gatekeeper accompanied me and observed the interview. Babs and Fiona asked the gatekeepers to be present at interviews conducted at the Sexual Health Outreach Project building. The presence of the gatekeeper raised questions of interference. There was a risk sex workers would give answers that would not offend the gatekeeper or risk the sex workers exclusion from the project (see Goode 2000). I in turn did not want to alienate the gatekeeper and risk losing their help, by asking them to leave when they had not been requested to stay (see Phoenix 1999). However, the presence of the gatekeeper did not appear to affect the answers given by the sex worker when compared with interviews when the gatekeeper was not present. In fact the presence of the gatekeeper enabled two of the interviews (i.e. Babs and Fiona) to take place providing valuable data. Although the gatekeepers were not passive and participated in the narrative the extent of any influence was limited to clarifying and supporting the sex workers.

During the interview with Polly her husband was present as despite the best attempts by the gatekeeper he would not leave the room. This was a difficult situation as it was his home and the interview continued with him present. From the start of the interview I was very aware I had to be careful what I asked Polly so as not to cause problems between her and her husband. He influenced her answers, overrode her when he believed she was giving incorrect answers and told her what he would allow her to do in relation to using certain health care services. Although his presence reduced the information I felt I could gain from the interview, his behaviour provided a good example of how outside influences can affect how sex workers make sense of their health needs. Dee's partner was present when I first arrived but she asked him to leave, he went upstairs, only reappearing when the interview was ending.

This completes the definition and reflection of the process of acquiring data. The next and final part of the methods section describes the process and procedures of analysing the data.

5. ANALYSING THE DATA

The use of discourse analysis from semi-structured qualitative interviews makes this research different from other research undertaken with sex workers and health issues (Woolley et al 1988; Harcourt and Philpot 1990; Ward et al 1993). Previous research is descriptive and prescriptive whereas this research is a subjective analysis to understand the construction and the underlying influences.

"The interpretation of data is at the core of qualitative research..." (Flick 2002, p.176). The process of analysis began before commencing the fieldwork while reading theory and previous research (Coffey and Atkinson 1996). It was while doing this work that initial theorising influenced the data collected during the fieldwork. The discursive constructs, discursive themes and sub-themes directed the interview questions and structure. With the research objectives in mind the questionnaires continued the process of analysis and from the data collected revision was made to the interview schedule before commencing the interviews. Cross-case analysis was performed based on the core questions, allowing a basic profile overview of the sex workers to be created. Continuous refinement during the interviews through reflection while transcribing focused the interview questions, allowing the interview to occur more easily but the data to remain consistent and comparable. As the interviews progressed the data gained was even more selective and relevant with issues adding to the discursive sub-themes.

Thematic indexing can be used to analyse discourse from many methodological and epistemological positions. The technique is used in a flexible way, enabling consideration of the multiple interpretations of and the influences within the data. It can be labourous and difficult to identify an end point although in taking time it is a useful tool to deconstruct and pattern match multiple discourses. I rejected using computer aided qualitative data analysis (CAQDAS) as I wanted to broaden my *"...conceptual, analytical and theoretical thinking"* (Mason 2002, p.153) by developing ways into the data to construct explanations and arguments. I needed to examine in detail small amounts of data to understand what was in and what lies beneath the data gathered. I wanted to know and own the data and although

there were thirty interviews in total the amount of data produced did not justify the time it would have taken to become proficient with the computer package.

Each interview was manually transcribed from the digital recording supported by the interview notes. The transcribing and reading of the interviews continued the process of familiarisation identifying further sub-themes for analysis. The discursive themes, discursive constructs from the literature review and sub themes identified during the interview process and transcription provided the initial 'thematic indexing themes'. These were reviewed and refined, identifying a thematic framework. The transcripts were examined and the statements relating to the 'thematic indexing themes' marked. On completion of the transcript review the marked statements were copied and placed under appropriate headings in the thematic framework. During the examination, consideration was given to Foucaltian principles (i.e. the underlying influences that direct the statement construction). New 'thematic indexing themes' were also added during the review.

Thematic indexing enabled the narratives told during the interviews to be analysed for similarities, differences and contradictions. Quotations to support the 'thematic indexing themes' were also entered into the framework. At the start this was a daunting procedure as it involved rigorous reduction of a large amount of data. However, as the analysis progressed, selecting data became easier and more systematic. The final part of the thematic indexing involved comparing the experiences and perceptions of the interviewees, searching for patterns/relationships and seeking explanations for these.

The thematic framework was analysed using Foucault Discourse Analysis to enable investigation into the interviewees constructions and the underlying influences that have directed attitudes and behaviours to health need and health risk. The final part of the analysis explains the constructions and their influences in terms of the discursive constructs identifying the differential construct and offering an explanation for the continuation of need when health care provision exists.

The multitude of discursive constructs, themes and discourses were bought together in diagrammatic analysis to help relate the research themes to published discourse (see Appendix B). The objectives of the study were to investigate need, risk, access and provision, they form the 'storyline' of the study and are the discursive themes which can be seen running through the discursive constructs of the discourses and the sex worker and

service provider interviews and analysis. The theoretical framework provides the thesis literature foundation and comprises the set of discourses (i.e. medical, moral, legal) applicable to the research, which have been reviewed with respect to the discursive themes, and explained within terms of the discursive constructs (i.e. pollution, rights, power, stigma, safety). The analytical framework identifies sets of concepts (e.g. health need, health risk) and theories (i.e. thematic indexing, cross case analysis, Foucault discourse analysis) used to perform the analysis, taking into account the influences of sex workers' and service providers' discursive frameworks. On carrying out the thematic analysis on the interviews with respect to the discursive themes, statement sets are produced resulting in discursive sub themes. These discursive sub themes can be explained in terms of the discursive theme and its inter-relations with the discursive constructs. All of this forms the discursive framework of the study.

II. PROFILES

The following section of the chapter describes the characteristics of the sex workers and service providers obtained from the interviews and cross-case analysis. The research context (i.e. 'Old Port') is described.

1. TWENTY ONE SEX WORKERS

Twenty one sex workers participated in the research, three were involved with the pilot study questionnaire and twenty were interviewed during the main study. The following provides the main characteristics of the sex workers interviewed, each identified with the use of a pseudonym chosen at random from a list. It illustrates the only commonality between the sex workers was they were all white of British origin. Babs had been born abroad but had lived in the United Kingdom for the last thirty years. Of the twelve sex workers who worked from the street, one used a flat in the red light district and a further five took the clients back to their flats. Nine worked from private premises (i.e. parlour, flat or home). The number of clients per week ranged from three to thirty five, nine sex workers spoke of twelve sexual attacks and eleven described seventeen non-sexual violent attacks. Of those who worked from the street, eleven identified violence as the main risk to their health and nine drug usage and/or mental health problems as the main health needs. 81% of all sex workers interviewed used some form of drugs. Of the remaining nine sex workers who worked from private addresses five could not identify any main risk prostitution posed to their health and none claimed to be dependent on drugs.

The youngest sex worker interviewed was twenty and the oldest was forty-nine, the mean age was thirty years. The average age that they started working was twenty one and three months, the youngest was thirteen when she started working. At the time of the interview three of the sex workers claimed they were not currently working. One had not worked for approximately eighteen months and the other two claimed they had not worked for between four to five months. Their experience of selling sex was varied and ranged from Kitty who had only been working for three months to Babs who had been working for twenty years. All of the sex workers interviewed recounted having breaks from prostitution ranging from a couple of weeks to two years.

Nine of the sex workers had children. Queenie and Belinda's children were adopted with no parental contact, Queenie's two boys had been adopted due in part to her problematic drug use. Tracey's son lived with her mother in a different city. Babs's children were much older and although they had been in care were all over the age of seventeen. All four women worked from the street. Fiona and Summer's children were older teenagers so although they lived at home there were no issues connected to childcare, work and appointments. Of the women who had younger children, Kitty, Lou and Polly worked around school hours, and had partners or husbands who could take care of them if necessary when the children were not at school. As with Fiona and Summer, Kitty, Lou and Polly did not have a problematic drug use or severe mental health damage which would make looking after children difficult. They were all very clear that where the children were concerned home and work life were separate and none of the children including the older teenagers knew what they did for a living. All five women worked privately.

The characteristics of the service providers who were interviewed will now be described.

2. SEVEN SERVICE PROVIDERS: TEN INTERVIEWEES

The level of contact with and the type of health care provided to sex workers varied with each service provider interviewee but this enabled full exploration of the variations and contradictions in their construction of health needs and health risks of sex workers. The service providers comprised a sexual health outreach project, statutory and voluntary drug agencies, HIV advice project, the police, a Genito Urinary clinic and a Family Planning clinic. Of these, sex workers mentioned the sexual health outreach project, both drug agencies and the Genito Urinary Service providers frequently, only one sex worker

interviewed mentioned using the Family Planning clinic and HIV advice project whilst two others dismissed the clinic as a beneficial service for their health.

It became apparent during the interviews that frequent contact with sex workers did not necessarily lead to contact with sex workers working in different categories of sex work. For instance although the sexual health outreach workers dealt solely with sex workers, they came into contact with mainly those who worked from the street. Also sex workers only came into contact with specific health services when a specific health need arose or when targeted by a health care service. The Prostitution Liaison Police Officer was interviewed to analyse how an individual involved in regulating prostitution and not actual health care provision constructed the health needs and health risks of sex workers and whether they were constructed differently from those service providers working in the 'caring' professions (e.g. doctors, nurses, social workers).

Variation in professional qualification and again the type of health care service provided was important as I wanted to ascertain the extent to which the construction of sex workers' health needs and health risks was dependent on the remit and speciality of the project, professional ideologies, personal bias, training and expertise of the project/clinic worker interviewed. Due to the need for clinical responsibility, the service providers from the traditional National Health services and services that involved invasive treatment or prescribing drugs had qualifications ranging from Registered General Nurse to Psychiatrist. Service providers working in the voluntary sector either had less traditional qualifications or had no formal qualifications but work experience. None of the service provider interviewees talked about or were asked about specific sex workers due to their strict codes of confidentiality.

Appendix C provides detailed profiles of each interviewee including a table of the salient characteristics of each sex worker

3. THE CITY

Old Port is an old naval town. One reason for carrying out the research in this city was that in the early 1860's Old Port was identified as being amongst the worse ports for 'diseased prostitutes' in England and Wales. As a result of the perceived danger that sex workers were believed to cause to the health of the military Old Port was one of eleven garrison and dock towns chosen for implementation of the 1864 Contagious Disease Act.

At the beginning of the twenty first century, of 35% of 'Old Port' households more than a quarter were living in poverty when measured using the 'Breadline Britain Score'. To obtain the score six variables are included, e.g. unemployment, lack of owner occupied accommodation and lack of car ownership, as well as three 'at risk' variables which are limiting long term illness, lone parent households, and low social class. The Breadline Score is obtained by summing the individually weighted variables. Levels of unemployment range from 2.6% to 19.7%. To try to address poor health and social exclusion Old Port has been awarded Single Regeneration Budgets and designated as warranting additional government support in terms of Action Zones. Each of these initiatives allocates specific social and economic resources for distribution to, and use by, residents, services and agencies within Old Port.

This chapter has described and reflected on the processes and procedures used to collate the data and implement the analytical framework enabling the analysis of the empirical data in the following chapters. Additionally it has provided the background to the research by describing the interviewees and explaining the rationale for choosing the city where the respondents both live and work. Chapter Four fulfils the first objective in identifying and examining how sex workers construct health needs and risks to health and the underlying influences.

Chapter 4

SEX WORKERS' CONSTRUCTION OF HEALTH NEEDS AND RISKS TO HEALTH

This chapter and chapter five document the analysis and illustrate that, far from being objectively measurable, sex workers' 'health needs' and 'health risks' are framed by, and constituted within the contextual environment of prostitution in 'Old Port' and medical, moral and legal discourses. The analysis will demonstrate how sex workers are governed in terms of their own and service providers' understanding of health need and health risk. It will explain where possible the way in which the construction of these discursive themes is affected by underlying influences (e.g. economic processes, social relations and institutions/power groups) and when appropriate it will illustrate conformity with and challenges against the dominant discourses (i.e. medical, moral, legal) and discursive constructs (i.e. pollution, rights, power, stigma, safety) identified in Chapter One. I use health need and health risk as discursive constructs rather than quantifiable objects, as I am not measuring the intensity of health need or risks to health. As will be shown, prostitution compounds existing, and creates new, health needs and risks to health.

The severity of health needs and risks undertaken are linked to the social, political and economic environment in which sex workers live and work. It is a combination of factors that leads women to sex work therefore increasing their vulnerability to the associated needs and risks. For instance if women were economically secure (Beck 1992; Phoenix 1999) and as the analysis will illustrate possessed greater degrees of mental and social well-being, some of the sex workers who were at high risk of harm (e.g. working long hours from the street while using drugs) would possess the necessary skills to work in safer situations or in different ways. The contextual environment of prostitution ensured sex workers interviewed wanted to remain concealed and not draw attention to themselves. On the other hand they wanted a loud enough voice to distance themselves from stereotypical ideas of prostitution and 'popular' notions of health need (e.g. HIV, STIs, use of crack cocaine), resisting the negative discursive construct of pollution within medical discourse.

Sex workers defined and categorised health need by whether they chose to act on it or not. Sex workers experienced or recognised a health problem, which, if affecting a combination of criteria, could be understood as a need requiring action. A health problem could become

a severe health need because it was initially ignored due to the criteria. The criteria are primarily occupational related suggesting an economic process in which the sex worker requires money for a reason (e.g. drug addiction, poverty), which influences the construction of a problem as a need. The health needs sex workers identified resulted in their inability *"...to change or cope with* [their] *environment"* (Bradshaw 1994, p.48). The sex workers talked at length of how health need interfered with their work and their inability to cope with social, economic and environmental situations. Sex workers exhibited a lack of social and personal skills caused by stigmatising and disempowering mental health needs and physical health needs, primarily caused by drug addiction. As analysis of the empirical data will show sex workers identified health need as damaged mental health, the effects of drug addiction and 'normal' STIs. The more severe the mental health needs, the heavier the drug use.

Sex workers identified 'abnormal' STIs and violence as posing a risk to their health. They compartmentalised health risks, risks were occupational. There were different levels of risk, some risks were ignored (e.g. pregnancy), many were downplayed (e.g. violence); it was a selective process. It is the intensity of need and risk, and the criterion, that makes sex workers different from non-sex workers. The distinction between health need and health risk for the sex workers appeared to be a temporal one. Health need even though long term and for some a health need since childhood, was a present need, whereas risk to health was based on what had happened in the past and very much based on the future.

This chapter will demonstrate that sex workers who were interviewed constructed health needs, and risks to health, within notions of responsible and irresponsible behaviour. If responsible behaviour (e.g. safer sex, safer injecting practice, not using drugs) was practised, then the perceived health needs of the sex workers and the risks to their health would be minimal. Any health care then sought would be viewed as preventative, rather than treatment. In contrast, sex workers claimed irresponsible behaviour (e.g. sex without a condom, sharing needles, working while under the influence of drugs) would most likely lead to serious infections and dangerous situations, risking the health not only of the sex worker, but the client and other sex workers. This behaviour has many influences, from other sex workers advising them of needs and risks at a peer level, partners (social relation), service providers' advice and treatment as an authority (power groups) to the media projecting public perceptions of sex workers within stereotypes, health and drug

campaigns (institutions) constructed within medical, moral and legal discourses outlined in Chapter One.

The following table provides an overview of health needs and health risks as identified by the sex worker.

Health Needs	Incidence	%of Sample
Damaged Mental health	11	52%
Drug Use - Addiction	8	38%
'Normal' STIs	5	24%
None	4	19%
Health Risk		
Violence and/or rape	11	52%
'Abnormal' STIs	6	29%
None	3	14%

Table 1: Overview of need, and risks identified by sex workers.

I. PRIMARY NEED CONSTRUCTION

The interviews allowed the analysis to explore how sex workers constructed their own health needs and those of other sex workers working in different locations (i.e. private and street). The following section illustrates that the severity and type of physical and psychological health needs these sex workers experienced were dependent on their life experiences (e.g. abuse) and lifestyle (e.g. drug use), also on the location from which they sold sex. Place of work became a factor affecting health as, on the street, physically dangerous situations were commonplace in relation to other working locations. The place of work was also relevant in connection with drug use and the associated health needs. Those sex workers interviewed, who worked from the streets and used drugs, believed they had very few options other than working from the street, due to the anti-drug rules of the parlours (Brewis and Linstead 2000a) and the long hours they needed to work to fund their drug use (Harcourt and Philpot 1990; McKeganey and Barnard 1996).

Sex workers working from private premises perceived their health need to be less intense than those working from the street. It will be illustrated throughout the chapter that sex workers working from the street constructed health needs, and risks to their health, very differently from those who worked from private premises. Those working in private premises described the street workers as different from themselves because they had a perceived greater incidence of sexual health needs and higher incidences of violence.

Interestingly, those working from the streets made no reference to the greater or lesser health needs or health risks of sex workers working from private premises.

The following section of the chapter discusses mental health, specifically the way in which sex workers believed work impacted on their mental health in relation to feelings (e.g. vulnerability and fear of rejection, intense self-loathing), damage (e.g. self-harm, and intensifying the symptoms of depression, psychosis, schizophrenia) and strategies to limit damage. Despite the wide range of symptoms reported by the sex workers, the generic term damaged mental health will be used throughout the thesis to identify all categories or typologies of mental health, as when discussing the symptoms sex workers did not construct categories of problems. The final part examines the complexity of drug addiction as a health need.

1. HEALTH NEED AS MENTAL HEALTH

(i) Damaged Mental Health

Eleven sex workers had serious mental health needs that had either framed or been framed by life events. As shown by the following quotations for some this damage was previous to, and made worse by sex work.

> *"I've been in and out of psychiatric care since I was 5 years old..."* (Maisie).

> *"I've had a history of admissions to psychiatric hospitals...I've had psychological problems, well, disturbances since childhood, well, since I was four years old really"* (Ebony).

> *"I was a complete fuck up before so what's the difference, I've never had much sanity"* (Nikki).

Indeed, mental health needs were the most pressing health need discussed. These ranged from mild depression to Post Traumatic Stress Disorder, psychosis and schizophrenia. The next section will examine how the sex workers talked about and made sense of the symptoms related to this damage; their feelings of vulnerability and fear of rejection by clients, intense self-loathing and self-harm.

(a) Vulnerability And Fear Of Rejection

Many of the sex workers talked about how involvement in prostitution required them to be both physically strong, in order to stand on the street for hours on end, and emotionally strong, in order to cope with the demands of the job and to survive. Drugs were believed by some sex workers to give them the emotional strength to cope with the job (McKeganey and Barnard 1992). The sex workers maintained they could not afford to be either mentally or physically vulnerable as they would be unable to work. However, despite constructing the use of drugs as a mechanism to protect their mental health the drugs in fact made them more vulnerable as the sexual exchange became driven by the need to earn money to buy the drugs, an economic process. In particular emotional strength was identified as an occupational qualification.

> *"Half the girls in this business shouldn't be in this business they haven't got the right mental attitude to do it. They see it as a quick way to earn money and it's not. It's* [a] *damn hard job. It's very mentally challenging and you have got to have a strong personality"* (Summer).

> *"Every girl that works on the street has to be very strong minded"* (Queenie).

The sexual exchange was 'mentally challenging' as sex workers talked about having to 'switch off' (i.e. not think about or feel what was happening), instead concentrating on more mundane ordinary tasks (e.g. shopping lists) to help maintain their mental health. These sex workers believed they were disengaged from the actual sex act (Barry 1995). They spoke of the requirement to emotionally detach themselves from the sale of their body. Nonetheless, for others, 'switching off' was not possible. They claimed this made them vulnerable to feelings of disgust, shame and low self-worth. This in part conforms to the discursive construct of pollution within moral discourse as outlined in Chapter One. The construct is so ingrained within discourse that sex workers were unable to resist the negativity of pollutionary claims (i.e. sex workers are morally 'polluted' and a moral 'pollutant') increasing their mental health vulnerability. As in the theoretical framework discussed in Chapter One the reality of the actual sexual act was too mentally taxing to allow separation of the body from the 'soul' (Edwards 1993). Prostitution clearly caused mental health needs for these sex workers. Sex workers explained the way in which vulnerability was lessened by not allowing certain actions during the sexual transaction. For instance a few who worked in the parlours claimed not to kiss their clients (Hoigard and Finstad 1992). Although there were no formal rules kissing was 'saved' for boyfriends not

clients, kissing was constructed as an intimate behaviour. For Katrina there was a clear distinction between lover and client, a boundary that she felt other sex workers blurred as,

> "*...they will treat them like lovers in the room, like you would your boyfriend. Sorry but no*" (Katrina).

Sex workers who worked from parlours talked about how rejection also led to feelings of low self-worth. None of the sex workers who worked from the streets mentioned client rejection impacting on their feelings of worth. This is curious, if only because these sex workers were openly on view to passing clients, who drove up and down until they saw a sex worker who they liked the look of. In the parlours when they were not chosen by a client sex workers described their self-image and self-confidence being damaged. Nonetheless, when discussing this aspect of their involvement in prostitution they also displayed a tremendous resilience.

> *"Every so often you think but what's wrong with me but then you just touch up your roots and do the make up again and you think but which one of us is the sad one, they are the ones having to walk through that door and pay to spend time with us I could go out anytime I wanted to and get company and I wouldn't have to pay for it"* (Summer).

Sex workers working in parlours also mentioned being vulnerable to feelings of boredom. They described being tied to a shift system and if business was quiet they had to stay at work, whereas, if business was quiet and they did not need the money sex workers working from the street reported going home. Despite working all their shifts in the parlour, the week before they were interviewed two sex workers reported 'doing no business' and five stated boredom lead to chain smoking and anxiety about loss of money.

Feelings of vulnerability compounded by the fear of rejection were not the most intense mental health need described. The dominant way of talking about mental health was how working combined, for some with the effects of childhood abuse, impacted on their feelings of self-worth. The following section will discuss this.

(b) Intense Self-Loathing

In the literature review in Chapter One sex workers were identified as possessing very low self-esteem with little regard for their mental or physical health (Matthews 1990). For those

interviewed mental health was very much associated with self-worth. Katrina who worked from a parlour thought sex workers working from the streets had little or no self-worth, in turn giving up on themselves (Barry 1995). For her, working from the streets would make her feel like a *"scumbag"* with no self-respect. To feel good about yourself and have self-worth, while prostituting, Katrina believed,

> *"[y]ou have to act high class, you have to be high class, you have to look high class"* (Katrina).

Katrina claimed if sex workers cared about both their mental and physical health, they would not put themselves at such risk by working from the streets. She believed sex workers working in this way could not be 'safe'. Katrina's narrative can be understood within medical and moral discourses in part confirming the discursive constructs of pollution, stigma and safety discussed in Chapter One. Sex workers working from the street were understood as 'scumbags' primarily due to the belief that they were infectious and connected with this their perceived inability to follow responsible behaviour. These sex workers were in turn stigmatised by parlour sex workers due to the very fact that they worked from the street with the associated risks (i.e. STIs, violence, drug use, damaged mental health). Lack of self-worth was linked by sex workers to the amount of money charged for the sexual exchange. They perceived the sexual act as less degrading if they were well paid for it. Only two mentioned what they charged and at the time of the interviews £40 appeared to be the 'going rate' for full sex from the streets. For Queenie £40 was too little, she said *"...you're not worth anything, you're only worth forty fucking pounds"*, increasing her feelings of self-loathing. The sex workers' bodies become a 'commodity' to be bought and sold in exchange for money. In literature the client assumes the right to buy her body for some form of sexual gratification (Barry 1995; Brewis and Linstead 2000b; O'Neill 2001).

Sex workers recounted the way in which feelings of worthlessness increased when they were offered less than the 'going rate'. Being offered less was explained by some to be a common occurrence when working from the street. Sex workers reported men would claim that they only had a certain amount of money and would play on the fact that business was quiet. Even when the sex worker refused, they claimed the men would often return later and *'try it on'* again. Such incidents as these were perceived as increasing the sex workers feelings of disgust.

> *"Just sex and oral but really dead cheap...I can't do that...it's disgusting for that little money I wouldn't do it"* (Diane).

The sex workers who worked in the parlours also talked about the way in which the sheer numbers of clients they had to engage with negatively impacted on their feelings of self-worth. Becki likened the client 'throughput' of a parlour, when it was busy, to a conveyor belt system. The client arrived, paid for their time, had sex, left and the sex worker moved on to the next client, with little time in between. The lack of social interaction with the client and the high numbers of different clients negatively affected her self-worth. Becki preferred working from a flat.

> *"It's more comfortable, find the clients nine times out of ten can be that much nicer...older gents that want a lot more time, a chat"* (Becki).

Buffy on the other hand claimed to prefer the busy turnover of the parlour as contact with the client had to be quick. Maisie had left parlour and escort work, preferring the street, as on the street, she could turn clients away. In this respect, Maisie believed street work allowed her the opportunity to both exercise her choice about clients and control the pace of work. An instance of the legal discursive constructions of rights (i.e. the right to 'choose') and power (i.e. the ability to exercise that 'choice') as understood by a sex worker. She believed this 'choice' decreased her vulnerability and limited damage within her lifestyle. This extends the viewpoint of power relationships discussed in Chapter One as in this instance Maisie's narrative resisted social and gender vulnerability, confirming a contract between consenting adults. She explained this, in turn, stopped her feeling the lack of self-worth she felt whilst working from parlours or escort agencies.

Feelings of intense self-loathing lead to actions that self-harmed. The type carried out and the reasons are discussed in the next section.

(c) Self-Harm

Four of the sex workers explained they self-harmed due to the intense self-loathing they felt. They constructed self-harm as punishment and a temporary release from self-loathing. The type of self-harm mentioned encompassed cutting themselves with blades, razors and glass, bathing in bleach, selling sex, drug use and attempting suicide. The sex workers who used drugs attempted suicide when they were not under the influence of drugs. They

described how when not taking drugs they had lost the 'numbing' effect that drugs provided and were unable to cope with the reality of their lives. The four sex workers who talked openly of attempting suicide, did so in a very unemotional, matter of fact way as can be seen by the following quotations.

> *"I've taken loads of overdoses, self harm, tried to hang myself, jumping out of windows loads of things. Most of the time I've been clean and just couldn't cope with reality"* (Abby).

> *"I've attempted to hang myself, I've taken overdoses before..."* (Ebony).

> *"Loads of times...topped myself, starved myself, gone over the top with speed I even went back on heroin to OD on heroin"* (Belinda).

Sex workers explained their feelings of worthlessness were in part due to sexual and psychological abuse that had occurred during their childhood, at home or at work, perpetrated by relatives, strangers, clients, partners or husbands. Out of the five sex workers who mentioned being abused as a child, two described the abuse that they suffered in childhood having a more adverse impact on their self-respect than selling sex. Research on survivors of child sexual abuse confirms the possible long-term effects of abuse as poor self-esteem and self-image, feelings of isolation and stigma, self-destructive behaviour (e.g. guilt, rage, grief, eating disorders), substance misuse and tendency towards re-victimisation (Wyatt and Powell 1988; Hall and Lloyd 1993). It indicates that the types of sexual abuse that have the most negative effects are acts perpetrated by fathers or father figures and abuse involving genital contact and physical force. A male relative sexually abused Lou when she was a child.

> *"I was abused as a child and that has probably screwed me up more, in fact I probably had less respect for myself when I was a non working girl than I did or do now..."* (Lou).

Sex workers claimed the abuse they suffered often led them to feel that they were not fit for anything other than selling sex. This can be understood in terms of moral and physical 'pollution' but not in the way described in moral discourses in Chapter One. Sex workers' perception of the immoral behaviour (i.e. childhood abuse, rape) was one that had been out of their control, they had neither choice nor power. They had been morally and physically 'polluted' by 'others' (e.g. male family members, partners, boyfriends) as opposed to the

moral construction of the sex worker as a 'pollutant'. Prior to working as a sex worker, Ebony had been raped when she was 17. As a result of the rape she described how she was unable to cope with the reality, started using drugs to block it out and developed a drug problem. The rape case was eventually dropped because the police deemed Ebony to be an "unreliable witness". It was evident that the inability to prove her victimisation deeply affected Ebony's feelings of self-worth.

> *'[I]t was the feeling that, that was all I was worthy of* [selling sex]*, all I deserved and I suppose I would rather feel painful emotions as a result of my own action rather than to be disempowered by anyone else's"* (Ebony).

The analysis indicates that prostitution in turn added to the majority of sex workers' destructive feelings of worthlessness and self-harm. For instance Belinda talked about cutting herself and bathing in bleach and disinfectant when she was abused as a child as a consequence of the self-hatred she experienced. That these were not one-off episodes was demonstrated by the numerous and deep scarring on her arms, hands and neck. Indeed throughout the interview Belinda continually scratched and picked at her skin. She had begun to self-harm again and as she explains this was a result of feelings of self-loathing engendered by involvement with street prostitution.

> *"The street used to really do my head in...it makes you feel like shit about yourself...'cause I started cutting myself again and using bleach...I had to stop* [working] *my head was going..."* (Belinda).

Ebony also linked self-harm to her involvement with prostitution. Although she contradicted the moral and physical discursive construct of pollution as discussed in Chapter One (i.e. sex worker as 'polluted'), her self-harm behaviour and narrative revealed feelings of 'being polluted' by sex work. She felt the associated stigma and suffered the resultant damage to her mental health, decreasing her safety further by self-harm. She was being 'polluted' and was not the 'pollutant'. Self-harm for Ebony was connected to and constructed by, the use of needles. Due to financial need Ebony had recently returned to working from the street after an absence of two years. She explained the only way she could cope with the feelings of self-hatred connected to selling sex, was to take drugs. She described how she stuck needles into her arm several times a day, as a form of self-punishment, an action over which she felt she had control. At the same time, she believed heroin acted as a block to protect her mental health, although as she goes on to say, reality resurfaces and,

"...occasionally you touch on this emotion, this massive self-loathing and [you need] *to harm yourself in any way that you can"* (Ebony).

An interesting viewpoint of power expressed as control but causing damage, even though Ebony feels in control the heroin addiction indicates she is not. As has been illustrated in this section, despite the mental health needs sex workers talked about, some of them possessed the ability to limit the damage to their mental health. The strategies used will now be examined including separation of work and non-work, constructing prostitution as work, a means to gain control and a sense of belonging.

(ii) Damage Limitation And Mental Health

Sex workers possessed differing abilities to limit the incidence of mental health damage. Those who appeared most able to limit the damage to their mental health were the non-drug addicted sex workers. Even so, as Lou recounted, working as a sex worker inevitably affected her mental health. For Lou the emotional and sexual relationship with her long-term partner had been made very difficult because of prostitution (O'Neill 2001). A few years previously, for a period of two years she had been celibate within this relationship, as she found it difficult to trust her partner and mentally switch off after work. She explained finding it difficult to distinguish between her partner and clients. Lou went on to say, *"I think that we are all screwed up from it* [prostitution] *in one way".*

(a) Separation Of Work And Non-Work

As in previous research (McLeod 1982; Barry 1995; McKeganey and Barnard 1996) in order to cope with these assaults on their self-worth, the non-drug addicted sex workers talked about maintaining a strict separation between their lives inside and outside prostitution. They described the need to protect their personal identity and lives by resisting the stigmatising identity of prostitution. Prostitution was constructed as having nothing to do with their personal identity. Their body was for work; the self was for their private lives as mothers and partners. They reported trying to maintain a separation of their identity. Containment and separation of prostitution as work involved many strategies. One strategy to achieve this was the use of a pseudonym. Sex workers who worked in parlours, claimed this work and home separation was easier to achieve.

"I can leave work at work I go home and I'm not Summer I am me, at work I'm Summer but at home I'm mum, I'm friend but I'm not Summer" (Summer).

The need to separate work and non-work is again illustrated by Summer. In separating her work and private life she is able to describe herself as ordinary, once she has left work. She uses terms 'straight' and 'real' to describe non-prostituting jobs, indicating selling sex is not understood as ordinary. Her narrative confirms the stigma within sex work expressed within moral and medical discourses that constructs sex work as abnormal and deviant defined in Chapter One.

> *"It's so nice to be able to leave here at the end of the day or half way through the day and be an ordinary person"* (Summer).

> *"*[E]*ven when I had straight real jobs I would meet a friend and we would go to the pub"* (Summer).

Sex workers claimed the ability to keep work and home separate helped to maintain mental health. Four described their private life as totally separate and different from prostitution. Katrina and Lou constructed the difference between having sex at work, and with their partners, in terms of the non-use of condoms (McKeganey and Barnard 1992) and the length of their non-work relationships.

> *"Oh no, no, no I've never used protection in my private life...I can't use a condom out of work because it's love, it's not porno star, it's love and it's different. Condom is what separates it, separates it between emotions"* (Katrina).

> *"They have always been long term relationships, I've never slept around or had one night stands"* (Katrina).

> *"I'm not the slightest bit promiscuous well I don't consider myself to be. I've stayed in a stable relationship, well it's certainly been a stable relationship in the last seven years"* (Lou).

(b) Prostitution As Work

Five of the twenty one sex workers claimed that sex work improved their feelings of self-worth. To reinforce this belief and protect themselves from the mental health damage they observed in other sex workers, prostitution was constructed as an acceptable way to earn money and emotionally unproblematic. Prostitution was described as a job as any other, it was a means to an end, to earn money. Thus the narrative illustrates these sex workers believed sex work decreased their economic vulnerability, it was not a direct result of

poverty as discussed in Chapter One. Sex work enabled them to pay the rent or mortgage, support their children and own a car. The sex workers explained sex work as a 'choice' of employment, they did not feel forced into it. For these sex workers there was little or no connection between working as a sex worker and their self-worth, beyond the pride they took in undertaking *'honest work'*. For Cath, prostitution was perceived as different, exciting and fun: different from the numerous 'normal' jobs (e.g. shop assistant); exciting due to the people she met and fun due to the companionship of the other sex workers. For these three sex workers prostitution was understood as what they did for a living. They made a point of saying that it was not who they actually were. While earning a living they believed they were hurting no one else and neither deserved nor conformed to the stereotypes attached to their profession.

These sex workers did however comment that if there was one problem inherent in involvement in prostitution it was drug addiction. Drugs were linked to taking away choices because of the urgency to get money to buy more drugs. The ability to choose was explained as paramount to safeguard mental health; if they were unable to choose they became vulnerable. Choice was explained as important in terms of clients, when to work and when not to work, if feeling unwell. Dee's

> *"...worse nightmare would be having to go and work and get x amount of pounds that day, I will never allow that to happen"* (Dee).

(c) Prostitution As Control

Sex workers who practised domination explained increased feelings of self-worth because while in the dominatrix role they had power. The belief of sex workers that they were in control of the sexual exchange challenges the legal discursive constructs of diminished rights and power, as the sex workers felt neither exploited or coerced. It was a sexual service between consenting adults as outlined in Chapter One. These sex workers believed they had the power to control the exchange, the power to punish the client and the power to cause them pain. They asserted that they had power at work, which was, or had been absent in their private life. They explained being confident and possessing feelings of self-worth, happiness and strength while in role. Polly felt in control of the sexual exchange as the majority of her clients were bound. She continued by saying,

> *"I love doing what I'm doing, not just the money like doing it seeing them squirm...they do as I say basically"* (Polly).

As such sex workers argued that being in control of the sexual transaction lessened their mental health needs as a consequence of prostitution. They maintained only certain behaviours were permitted in relation to which areas of their body the client was allowed access to and what the client was allowed to do. Twenty sex workers claimed they did not allow anal sex; the exception was Nikki who was a transsexual. One sex worker only sold oral sex and all claimed they refused to sell 'water sports' (i.e. passing urine on the client).

Summer explained control in the parlours was maintained by making the client aware that he was paying for time and not a particular sexual act, *"[w]e do not sell sex we sell our time".* In this way, if the sex worker was uncomfortable with the client, Summer maintained they would not have to have full sex, a massage would suffice. Sex workers constructed a clear demarcation between their body and 'soul'; their body was involved in the financial transaction, the soul was not. The body was only involved for the shortest possible time, the time it took to earn the money, and was not sold but rented. Renting as opposed to selling was a very important distinction for the sex workers. In renting their bodies they believed they still owned it during the sexual exchange. As Katrina adamantly stated *"I rent my body not my soul".* However, on interviewing May, from the same parlour, she assured clients that all services were full services which would leave little room for negotiation once they were with the client in the room. The price difference was due to time difference ranging from fifteen to sixty minutes. Summer explained control of the sexual exchange in the room was imperative. If she did not have control then she could not work because,

> *"...in my private life I have been abused and I am not going to be abused again"* (Summer).

If control of the actual sexual exchange was lost, as in the case of rape by a client, for some of the sex workers control after the rape was described as very important. Here, control meant ensuring the assailant was caught. On being sexually attacked for the second time Tracey made sure that she had DNA from her attacker so that the police could use it as evidence. While Tracey was being attacked in an abandoned car that the assailant had dragged her into she pushed the assailant's arms and hands against metal and broken glass. Straight after the attack she flagged down a passing police car. She had blood from the assailant on her clothes. In order to protect her own mental health Tracey explained she had to ensure the assailant was punished.

> *"I was abused when I was a kid and there was nothing that I could do about that so I suppose since that I was determined that if ever it was going to happen they weren't going to get away with it"* (Tracey).

(d) Prostitution As Belonging

Some of the sex workers explained the way in which prostitution provided them with a sense of 'belonging' or a sense that they were part of a wider community. Even though the majority hated what they were doing, the sense of belonging was important. However, they acknowledged their need to belong made them vulnerable to behaviour that could damage their health. As Kitty suggests, it is

> *"*[v]*ery hard to find someone in the business that has not been through some form of trauma, somebody that has an absolutely perfect life you wouldn't find in this situation* [prostitution is full of] *very vulnerable people that get used"* (Kitty).

So, despite the potential for harm, it became clear prostitution gave some sex workers a reason to go out, to meet people and friends. They explained 'belonging' to the world of work and were able to support themselves. For Katrina the money earned from prostituting bought her respect and got her noticed *"...it doesn't matter how busy restaurants, clubs, hairdressers are, money talks."* She claimed being able to financially support family and friends and she believed money bought her acceptance outside the world of prostitution. For some who had tried to stop prostituting, long absences from prostitution lead to boredom, loss of 'good' money, loneliness. For these sex workers prostitution was seen to provide a social network of friends who they did not have to lie to because they knew they solicited, they understood the risks involved, they knew the same people and very often had the same drug habit or addiction. Work gave the sex worker something to do, a reason for being and somewhere to belong. This belief confirms the legal discursive construct of power discussed in Chapter One that sex work increases their social vulnerability outside of sex work. Maisie explained she had found moving away from the red light district the only way to reduce her drug use but had found leaving extremely difficult, as she had known little else since the age of 16.

> *"*[A]*t the beginning I couldn't cope with it all I kept on trying to get back, you know I missed the life of prostitution"* (Maisie).

The next section of the chapter will examine how sex workers talked about drug addiction, as a health need. Addiction was a major health need for eight sex workers.

2. DRUG ADDICTION AS HEALTH NEED

Sex workers linked health need to the use of injectable habit-forming drugs. All of the eight sex workers who worked privately and who were either non-drug users or who used drugs recreationally, argued that it was drug addiction that created the situations that lead to other sex workers' increasing health need. Sex workers used the term addiction to describe drug misuse that signified both a physical and psychological dependency. Therefore if a certain type and quantity of drug was not taken, symptoms of withdrawal would occur. As discussed in the theoretical framework in Chapter One (Sussman and Ames 2001) addiction for the sex workers symbolised drug misuse that they could neither predict nor control and took over their lives. Drug usage was believed to both reduce and mask the symptoms of other health needs, specifically damaged mental health. As the empirical data will illustrate sex workers talked about drugs as providing support to cope with their personal and working lives. Sex workers working from private premises talked about drugs signifying weakness and described those who used drugs in the derogatory term 'smackhead' which symbolised the most irresponsible drug use.

The next sections illustrate how sex workers explained drug addiction, not only in terms of drugs providing support but also symbolising weakness, the correlation between the category of 'smackhead' and the use of needles and the physical health needs caused by drug addiction. It will explain both conformity with and resistance against dominant discourses and discursive constructs, illustrating drug addiction as a health need is a major concern in relation to the 'control of infection', the constructions of sex workers as moral and physical 'pollutants', and sex workers being 'safe' from 'pollution'.

(i) Drugs As Support

Sex workers identified drugs as giving them the necessary psychological support in order to work. However, addiction created a damage relationship in which they needed to use drugs to be able to work, but had to work to get drugs to prevent withdrawal. The drugs were understood as providing a coping mechanism, which, blocked feelings of anxiety and self-loathing, and helped them to forget past (e.g. childhood abuse, rape) and present (e.g. the act of selling sex) traumatic experiences. Two sex workers claimed illegal drugs masked the symptoms of their mental health needs more than General Practitioner prescribed drugs. Drug addicted sex workers believed the psychological and physical support that drugs gave them was a clear justification for drug use, behaviour deemed irresponsible by non-addicted sex workers.

Maisie, in common with other drug-using sex workers, could not go to work *"straight"* because *"...it's too much of a head fuck without* [the use of drugs]*"*. The relationship between sex worker, and heroin for example, was talked about in terms of friendship. For these sex workers heroin offered the same support and cushioning from bad experiences that a friend could offer by providing a *"...nice, white fluffy cloud around you"* (Queenie). Sex workers believed the 'cloud' protected them from the emotional effects of selling sex. This positive concept of drug use as a coping strategy contradicts the medical discursive construct of pollution from and addiction to drugs as outlined in Chapter One. Drugs enabled them to work to earn money, in part reducing economic vulnerability but enabling them to buy more drugs, limiting the control of infection. Without the drug use sex workers described themselves as too ill to work and due to financial need they could not let this happen. When talking about their health needs these drug-addicted sex workers spoke of urgency and immediacy rather than long-term consequences. Quite simply they just wanted to stop the physical symptoms of withdrawal. They constructed the problems as simple mechanistic ones: the need for clean needles and 'Sharps bins'. In short, drug-addicted sex workers believed illegal drugs gave them the strength, specifically emotional strength, to work.

(ii) Drugs As Emotional Weakness

In contrast, sex workers who did not work from the streets understood drug usage, especially heroin and cocaine, as a symbol of emotional weakness and this is the theme I shall now discuss. Sex workers explained those who needed to use drugs in order to work were to be pitied as the use of drugs clarified they were not psychologically strong enough to withstand the emotional effects of selling sex. At the same time parlour working sex workers blamed drug-using sex workers for undertaking irresponsible behaviour and creating the situation they were in (i.e. working from the street using drugs). The street working sex workers were to be blamed, as they did not possess the emotional strength or courage to work without drugs. Thus parlour working sex workers' narratives confirm medical and moral discursive constructs of pollution in respect to drug-addicted street sex workers being moral and physical 'pollutants', unable to control infection. This is an interesting aspect, as the construction of the sex worker as 'polluted' is usually expressed by those external to the sex worker community.

In the two parlours where I interviewed sex workers, prescribed drugs were the only reported types of drugs permitted on the premises. Sex workers working away from the

street believed that desperation for drugs dictated the sexual contract and sexual exchange on the street (Matthews 1990). They argued drug-using sex workers not only brought prostitution into disrepute, but influenced the price of the sexual exchange (Mahar 1996, Dalla 2002). According to Katrina,

> *"...business has been ruined for girls like me because I used to get 80 quid for fifteen minutes, now I get 25 or 30 quid for half an hour. That's a hell of a come down in money just because of stupid little bimbos that don't know what they are doing"* (Katrina).

Street sex workers were thought to be frantic due to their intense need to earn money to buy drugs. For the non street sex workers' this frantic need for drugs further illustrated street sex workers weakness as not only had they to take drugs to be able to work but they were unable to control their drug use. Those working in parlours talked about sex workers working on the street as being cheap (e.g. reducing prices to attract trade) tarts (Venema and Visser 1990; McKeganey and Barnard 1996). For some sex workers, taking drugs in order to work was irresponsible, weak behaviour because in their narrative it was linked to self-inflicted infections and violence.

> *"Me personally don't see why they have to...*[T]*hey haven't got the outlook that men use women and why can't we turn around and use them. They have to get over the initial hurdle, have the willpower and strength to do that"* (Fiona).

> *"When I first started this job I thought that at the end of the day there is no point in doing this job if you have to take drugs and drink to be able to work, if that time comes then it's time to leave"* (Cath).

(iii) 'Smackheads' And The Use Of Needles

There was a clear separation between sex worker drug users who used needles and those who did not. The reasoning behind the use of the term 'smackhead' will now be examined. Many sex workers distinguished between drug use that was responsible and drug use that was irresponsible. Responsible drug use was recreational, and linked to the use of alcohol and non-injectable drugs; these were all understood as non-addictive and a 'non-pollutant'. Irresponsible drug use involved, first and foremost, injecting dangerous habit-forming drugs. Street work was understood as being hierarchically organised by the use of needles, those injecting drugs worked a different section of the street than non-injecting drug using sex workers. Katrina used drugs recreationally but denied categorically that she was a 'smack

head', *"I'm not an addict in any way, shape or form. I can take it or leave it".* For sex workers from the street, 'smackheads' symbolised the irresponsible level, type and pattern of drug use. 'Smackheads' were constructed as sex workers who were linked to the use of needles to inject heroin. Sex workers associated needles with dirt and cross infection constructed in terms of 'pollution' and safety within and conforming with moral and medical discourse as discussed in Chapter One. As such those who used needles to inject drugs were considered to be deviant. 'Smackheads' were understood as the most irresponsible of all drug users, there was no justification for this type and level of drug use.

> *"I think that it's just the ones on the needles on the hard drugs that are up to no good"* (Angela).

> *"There are rumours going around that most of the girls on the street are smackheads and that is why they are doing it to feed their habit"* (Summer).

It was clear that needles for a few of the drug using sex workers represented something to fear. Fear of needles, or the inability to find a vein, were explained by four sex workers as the main reasons why they had either not used habit forming drugs or injected drugs. Nikki would inject other people when she saw they were making a *"...real hash of their arm"* but would never inject personally due to *"...an allergic reaction to needles".* Angela believed that her fear of needles was one reason why she had not touched *"hard drugs".* However, it was explained that using needles to administer drugs decreased the amount of drugs needed to obtain the same effect. When Maisie injected heroin the daily cost of the drugs was reduced from £180 a day, (when smoking), to £60 a day (when she injected). This dramatically reduced the number of clients, and hours worked during the day but Maisie identified the negative effect as *"I used to mess my arms up something chronic".*

Abby started to inject heroin after she had been admitted to hospital, she described needing treatment following an attempted overdose. Before the admission she explained she had been unable to find a vein, she had smoked heroin, but had not liked the taste of it and the heroin had little effect on her. On discharge however,

> *"[i]t sounds really stupid but they had put a drip in my hand so there was a mark going into my vein so I went into that mark and that is how it started"* (Abby).

Since using heroin intravenously, due to desperation for drugs, Abby admitted openly that she had shared needles, behaviour that had the potential to spread infection (e.g. HIV/AIDS, Hepatitis C).

> *"I'm ashamed to say sometimes, well most of the time...if there was a shortage of needles or pins I would try and use the needle first but it don't always work out like that. It's also not only using the works but it's using the spoon, the filter, the water"* (Abby).

Abby was the only sex worker who talked about sharing needles, despite the fact that the others using drugs declared that they were, on numerous occasions *"...completely off their heads"* due to drug usage. These sex workers assured me that they were always *"aware"* of the need to use and to have supplies of clean needles. These assurances of using clean needles and the portrayal of an awareness of risk illustrate a need to resist the moral constructs of 'pollution' (i.e. physical 'pollutant') and stigma (i.e. attached to irresponsible behaviour) as discussed in Chapter One, and confirm the discursive construct of safety (i.e. personal responsibility, safer from infection). The use of clean needles by drug-addicted sex workers represented responsible actions within behaviour deemed irresponsibly by non-addicted sex workers.

(iv) Drug Misuse: Physical Health Damage

Drug use, in turn was reported to create its own short and long-term physical health needs. The physical side effects (e.g. infection of injection sites, loss of self image, dietary problems) caused by using drugs, were not identified as a priority for drug-using sex workers. For those not using drugs, they were a major concern. Maisie in common with all sex workers using habit-forming drugs, did not construct her health needs caused by drug usage in terms of infection or of being a 'pollutant', but how drugs affected her day-to-day life, *"...messing you up you know, can't eat, can't do fuck all".*

Liz linked health needs to injection sites. Due to *"having no veins"* in her arms Liz described how her sister had shown her where to inject into her groin. Despite swelling in Liz's leg and ankle, her sister being admitted to hospital and spending time on a life support machine due to a blood clot caused by using the groin as an injection site, Liz continued to inject in this way claiming *"...that's the only place I can go".* Two sex workers, Maisie and Ebony, talked briefly about health needs caused by amphetamines. A year and a half before the interview Maisie had been admitted to hospital with heart failure and pneumonia,

the reported cause was amphetamine use. She was eighteen and a half when admitted to hospital and has not used amphetamines since. Ebony on the other hand, mentioned *"quite a few"* admissions into hospital, due to amphetamine psychosis, but reported continued use of amphetamines on a regular basis.

This section identified the way in which sex workers' construction of mental health and drug addiction was understood in the context of prostitution, how sex workers identify a problem as a need, the strategies they follow to reduce the symptoms and effects on their work. It elaborates the interpretations and contradictions in their understanding and use of drugs, the resultant behaviours and damage. It illustrated the way in which their narratives conformed or challenged with the moral, medical and legal discourses outlined in Chapter One.

The sex workers' construction of mental health need is identified as a problem that is self medicated via drugs or mental strategies. When their ability to work is reduced below an acceptable level, takes over their lives or requires some form of intervention they then identify the problem as a need. It is at this point the need requires an action, either increased or different forms of self-medication or health care provision. Despite their general lack of power they are desperate to exercise control over certain aspects of their lifestyle even to the detriment of their health.

The sexual abuse by important others in terms of power and social relations has influenced some sex workers' construction of need as well as causing damage. Their vulnerability and self-loathing relates strongly to the experiences of the sexual exchange and the attempts to alleviate the damage. It could be considered that the type of client and the way the exchange was performed influences this knowledge of the exchange. Their separation of work and private life and identifying prostitution as work and control has been directed by wanting to be considered 'normal' and 'ordinary' and not be stigmatised. These constructions are influenced by the legal system, health care providers and the general population.

It was not possible to interpret from the narrative what underlying influences, apart from experience of use, have directed the street sex workers construction of drugs as a support mechanism. Non-drug using sex workers, particularly those from private premises, have been influenced in their construction of irresponsible behaviour, specifically drugs as

emotional weakness and the damage caused from their interactions (social relations) with addicted street workers.

The following sections will discuss the ways in which sex workers talked about, and how they perceived risks to their health. The dominant health risk identified by sex workers was violence.

II. PRIMARY RISK CONSTRUCTION

When sex workers talked about risk, the construction of behaviour as either responsible or irresponsible was continued. Working from parlours was believed to be more responsible and safer than working from the street, drugs were safer swallowed or smoked rather than injected, regular clients were safer than non-regular clients and rules within the sexual exchange only allowed certain responsible behaviour (e.g. no kissing). Sex workers challenged the notion that they undertook high-risk behaviour without adequate precautions. By claiming to follow responsible behaviour they tried to resist the perceived negativity attached to the discursive constructs of safety, stigma and 'pollution' within the medical and moral discourses outlined in Chapter One. Sex workers wanted to be seen to be 'safe', to reduce stigma and not to be perceived as a 'physical pollutant'. Summer and Fiona believed themselves to be important, therefore so was protecting their health against risks. They believed in themselves and talked about possessing self-worth. For instance, sex was always,

> *"...with* [a condom] *I value my life slightly more than that...and you couldn't afford how much it would cost to have it without"* (Summer).

> *"You've got to make sure that you are safe yourself..."* (Fiona).

Sex workers talked about and understood risks to their health in varying degrees of seriousness and linked to certain behaviours. As the following quotation from May illustrates, there were different levels of risk and personal responsibility. Some activities were deemed not a high enough risk to warrant responsible behaviour even though the activity involved bodily fluids deemed to contaminate in other situations (i.e. penetration).

"Well I don't take risks, never have, never will, there's no money for it. I've never done anything without a condom...well there is hand relief but that's it" (May).

1. VIOLENCE AS A RISK TO HEALTH

The following section will illustrate risk of physical harm was not a concern for sex workers working in the parlours, but was identified as a fear for those working from the street. Sex workers talked about violence being the result of an individual's behaviour and drug use. They believed if sex workers did not take adequate precautions when working, and worked while taking drugs, then if they were attacked they had only themselves to blame. This attitude conforms with the moral discursive constructs of stigma and diminished rights. Violence was constructed by sex workers to be an occupational hazard, a risk and side effect that went with the job (Barnard 1993; Miller 1993; O'Neill 1997). The aspects of fear of, blame for and cause of violence will now be discussed. Despite sex workers speaking of control and power, and resisting the concept of exploitation, diminished rights in relation to violence were very much in evidence in their narratives confirming the legal discourse as described in Chapter One.

(i) Fear Of Being Attacked

For sex workers working from the streets, risk of violence was identified as posing a number of fears. It was explained that both the uncertainty and certainty attached to violence was feared. Uncertainty as in the extent and nature of violence and uncertainty when violence was going to occur combined with the certainty that it would occur at some point in their working lives based on past experiences of violence. It was the risk of violence occurring ranging from rape, sexual assault, kidnapping, attempted murder (e.g. strangulation), being hit, stabbed, and handled roughly and the psychological trauma of being a victim of past violence, which was identified as leading to drug use. The interviews indicate that violence takes many forms. For instance seven reported being raped, three of these sex workers had also been sexually assaulted on different occasions, ten sex workers described non-sexual assaults, one of these had been attacked on three separate occasions.

Eleven of the sex workers who worked from the street blamed anxiety, linked to the fear of being attacked, for using drugs. Abby and Maisie both talked about the necessity to use drugs to block the feelings of trepidation associated with working from the streets. They claimed drugs were used for a purpose, to give them the ability to work disregarding the notion of addiction within the medical discourse outlined in Chapter One. They believed

drugs kept them 'safe' from further mental health damage but ignored the fact that in dulling the senses drugs put them at increased risk in dangerous situations.

> *"The drug use helps with the anxiety. I often use before I go there* [red light district] *or else I wouldn't be able to go"* (Gillian).

> *"I have to do drugs or have to be drinking I can't go straight because it's too much of a head fuck, you think about it all the time"* (Maisie).

Three sex workers, who were working in the parlours, believed pimps perpetrated the violence on the streets, even though none of those interviewed mentioned having a pimp. Katrina, who worked in a parlour, thought that working from the street provided little escape from violence. She said *"...if your pimp don't beat you up, the other girls will"* dispelling the belief of friendship and support among street sex workers. Although violence was identified as the primary health risk, sex workers stated they could not afford, mentally or physically, to make it an issue. They believed if they thought about violence too much they would not be mentally strong enough to be able to go out and work. All of the sex workers claimed regular clients provided a welcome break from the risks of working from the street, as regular clients were described as a known entity and, therefore, posed less of a risk to their physical health (Barnard 1993). All sex workers identified having regular clients. However, they acknowledged they knew nothing, or very little, about the majority of their clients: Queenie described every client that she went with as a potential risk to her health.

> *"I get so scared, going out there every night, getting into every car thinking this is going to be the man* [that will kill me]*"* (Queenie).

It became clear that to cope with the fear, sex workers often distanced themselves by claiming that dangerous situations happened to other sex workers and not to them. When they talked about episodes of violence, they drew on notions of normality, as well as blame and victims. As Hoigard and Finstad (1992) explain, violence is understood as normal for sex workers due to early socialisation to it but the effects of socialisation are compounded by a working lifestyle that routinely involves degradation and insults turning the abnormal (i.e. violence) into the normal. Some sex workers confirm this, constructing violence as to be expected in certain situations, they are not entitled to be 'safe'. Their viewpoint of accepting violence is based on the moral discursive constructions of diminished rights and safety discussed in Chapter One. The moral discourse maintains the view that sex workers

are deserving of violence and lack rights. Evident in sex workers' narratives was the belief that certain behaviours justify some forms of punishment conforming with the moralistic attitude. Although working with others reduced the risk of violence, Becki who worked indoors (e.g. parlours and flats) with other sex workers had been raped at knifepoint (Brewis and Linstead 2000a). She did not think one rape in seventeen years was alarming, *"...given that it can happen anywhere".*

Violence at home was not raised by sex workers as being a current concern, although Fiona described herself as an *"ex battered wife".* Katrina had been severely beaten by an ex boyfriend and, Abby, had been regularly beaten by her ex pimp, but at the time had not thought of this as being unusual.

> *"My pimp used to batter me up but that was just normal, well it's not normal but it was normal then"* (Abby).

(ii) Violence As A 'Just Desert'

Despite Abby's experience of violence at the hands of her ex pimp, she still identified and constructed violence as predominately a risk from clients. However, Angela associated harm to her personal safety and health with some of the other sex workers fighting, arguing and 'taxing' (Dalla 2002). When working, Angela kept away from other sex workers, protecting herself from them, but increased her isolation and therefore increased the risk of violence from clients.

If sex workers were caught stealing from clients and this resulted in violence, then the sex workers claimed they had only themselves to blame as they were committing a crime and reneging on the sexual contract. Although the majority of sex workers blamed 'smackheads' for the increase in robbery, theft from clients was explained as not solely due to sex workers' use of drugs and the need for money. Sometimes sex workers reported robbing clients as a way of 'getting back' at them for previous attacks. However, they admitted stealing from clients led to the risk of indirect retribution, as some clients, who had been robbed by drug addicted sex workers, came back to the patch with the sole purpose of seeking revenge for the theft. The revenge was taken out on the sex worker they picked up at that particular time. When some of the sex workers recounted these tales, they absolved the men from any blame, by blaming the violence on the unsafe actions of other sex workers.

In fact, a few of the sex workers talked about some of the victims of violence as 'deserving it'. Violence was constructed as a 'just desert' for irresponsible behaviour, illustrating conformity with the moral discursive constructs of pollution, diminished rights and power relationships as outlined in Chapter One. They claimed the sex worker was at fault because she had been using drugs or had got into a car with more than one man or with a certain 'type' of man. Sex workers associated the risk of violence with certain 'types' of men (Phoenix 1999) and these were the clients to avoid.

> *"*[A] *lot of girls gets raped and in a way you've asked for it cause it's bad enough getting in a car with one bloke let alone getting in a car with two blokes. I mean there's one girl that got in a car with five of them, she got gang raped, well where's the common sense"* (Michelle).

Other sex workers blamed themselves for the violence. They reported placing great importance on being in control of the sexual exchange and being able to 'read' the client (Stanko 1985; Edwards 1987; McKeganey and Barnard 1996). Client compliance was understood to be an integral part of the job; if co-operation was not gained sex workers felt they were to blame for the attack. Blaming themselves and not the perpetrator enabled sex workers to believe that violence could be prevented by changing their behaviour as it was something they had missed which had led to the violence. Sex workers talked of how they had been fooled by the initial 'safe' looks of the client. Babs explained she had a *"faultless record"*, with no physical attacks during the twenty years she had been working from the street that is until a year before the interview. After two recent attacks she believed she was losing her intuition, that she was getting too old to be able to *"suss out"* the true nature of the client and, therefore, the attacks were her fault, as with her experience she should have *"known better"*.

> *"I've been working the street for 20 years and I have not been attacked before last year. I'm usually good and can tell...they both fooled me, just too slow"* (Babs).

In a few instances the attacker was described as having a split personality, being 'safe' at the beginning of the sexual exchange but at some point (e.g. once the woman was trapped in the car, during the sexual act or after the sexual act) changing into an individual who was to be feared and who posed a risk to their health.

'[T]his person was a Jekyll and Hyde person...I always thought that I was quite a good judge of character..." (Liz).

'[I]t's a risk that you take, you just don't know they might look alright but they could turn nasty, you know you just don't know really" (Diane).

For Kitty the personality of the client changed when he put on a different pair of glasses. To begin with Kitty described the client as a *"really nice chatty bloke"* but on putting on a pair of black-rimmed glasses *"he was a completely different person"*. Kitty blamed the assault on her inexperience and her desire to be a mistress. She explained she had not wanted to refuse the client, or make a fuss while he was still in the parlour, as she had the misguided fear of losing her job and also losing the chance to train to be a mistress. Kitty's fear of losing her job illustrates her diminished rights and the dynamics of power relationships, specifically gender vulnerability as discussed in Chapter One. On the other hand Kitty's narrative resists the coercion/exploitation arguments made within legal discursive constructs; she *"wanted"* to become a mistress.

This section has illustrated the perception of clients as both 'normal' and 'abnormal' men. Normal as in ordinary and biologically driven, abnormal in terms of the potential for violence (Phoenix 1999).

(iii) Violence Due To Drug Usage

For many of the sex workers violence was explained and understood as a by-product of drug use. Drug addiction ensured sex workers could not be 'safe' from 'pollution'. Lou believed addiction in itself made the sex worker the victim of every client she *"went with"* as drug addiction took away choices. If sex workers did not have a drug addiction they were perceived to have more choices, when or where to work, which clients to go with. Not having a drug addiction meant sex workers could turn down clients they felt uneasy about, if only because they could physically afford to wait for the next client without the fear of withdrawal. Also sex workers believed they would not be under so much pressure that they felt the need to agree to unsafe sexual acts in order to earn more money. When taking drugs, the scale of the risk undertaken was counterbalanced by the need to earn money. As Abby explained,

"I've had my run-ins over the years but I haven't really cared to be honest because of being too off my face" (Abby).

Non-addicted sex workers asserted that drug-use reduced awareness, clouded intuition and thus reduced control of the situation. Katrina described how drug use increased the risk to health, in terms of how clients treated addicted sex workers (e.g. not deserving respect and therefore deserving violence).

> *"[I]f you're a smackhead no one cares, they have no respect for you and they just treat you like dirt"* (Katrina).

Katrina believed working in private premises increased the respect clients felt towards sex workers; clients knew that drugs were not allowed on the premises. Her narrative challenges the medical and moral discursive constructs of pollution, stigma and safety discussed in Chapter One. Although she stigmatised street working sex workers she wanted to ensure that not all sex workers were categorised as 'pollutants', injecting illegal drugs in an irresponsible way. This extends the construction of the sex worker as 'polluted' as the construction is being made from within the sex work community rather than being expressed by those external to the sex worker community. A few non-drug using sex workers, particularly those who were older and more experienced, talked almost exclusively about drug-addiction hampering sex workers' ability to adapt their behaviour and therefore increasing the risk of violence. They believed any risks to sex workers' physical health could be prevented by adapting their behaviour during the sexual exchange. For instance, Lou who had worked from a flat on the red light district for seventeen years had not been physically harmed. She was a non-drug users who, should violence occur, believed herself to be fully able to cope. Lou had been in several situations which posed a risk to her health, (e.g. trapped in a client's car, diverting a violent client from an inexperienced drug-using sex worker), but she had not been physically injured. Both Dee and Lou agreed that their manner with the clients, and for Lou her large physical frame, helped prevent injury as they were not incapacitated due to drug use.

> *"If someone is aggressive and you get aggressive with them then that is going to make them doubly aggressive so keep a big smile on your face when you have a dead awkward bugger, keep them talking, keep them sweet, keep it friendly"* (Dee).

> *"I didn't scream or fight or shout or swear because all those things could have got me seriously hurt...and I managed to talk him round"* (Lou).

This section has examined how sex workers construct violence as a risk. Sex workers working from the street believed assault was certain and feared, but mitigated by faith in their intuition and adherence to responsible behaviours. When this failed they blamed themselves or other sex workers, particularly those addicted to drugs. The knowledge that 'assault was certain' was to a large degree influenced by their personal experiences of violence and the stories recounted by other sex workers (social relations). The attitude of 'violence deserved' has foundations in responsible/irresponsible behaviours, the certainty of violence and the necessity of work, influenced again by other sex workers (social relations) but also reinforced by 'pollution' commentary within the media. It overrides their belief of any rights they may presume to have to safety. The understanding of violence caused due to drug use has been influenced by their personal experiences and their reduced physical and psychological ability when using drugs, observation of the effects of violence on other sex workers and discussions with other sex workers (social relations).

III. SEXUALLY TRANSMITTED INFECTIONS CONSTRUCTED AS NEED & RISK

Sex workers understood STIs in two ways. Firstly, as unavoidable caused by the act of sex involving responsible behaviour and sexual cleanliness and therefore a need. Secondly, as the consequence of irresponsible behaviour and the practice of unsafe sex and therefore a risk. These aspects of their construction will now be explored.

1. RESPONSIBLE VERSUS IRRESPONSIBLE SEXUAL INFECTION

The analysis indicates that sex workers linked different types of STIs to varying levels of personal responsibility. Responsible sexual behaviour was linked to acceptable work related sexual health needs. Sex workers believed they were 'safe from pollution', their behaviour enabled them to control infection, resisting the concept of sex workers as a 'physical pollutant' constructed within medical and moral discourses outlined in Chapter One. Cystitis, thrush and general soreness were all to be expected and were constructed by the sex workers as 'normal' (i.e. typical). Non-sex workers suffered from them as well, they were minor needs to be expected due to the nature of the work even though some sex workers reported these infections caused continual symptoms. Sex workers explained these infections and symptoms could be caught or present even when a condom was used and with long-term partners. May reported suffering from

"...thrush and cystitis but sometimes I've been getting that even when I haven't been working. I think I'm just prone to these things...you don't have to be in the sex industry to get it" (May).

In fact, some sex workers stated protected sex using condoms caused soreness due to the irritating effects of latex and spermicidal lubricants. It became evident that 'normal STIs' were so probable and a part of the lifestyle that they were not considered on their own as a risk.

Herpes, HIV/AIDS, syphilis and gonorrhoea were constructed as 'abnormal' STIs, risks associated with irresponsible sexual behaviour linked by sex workers with deviancy, filth and blame. Therefore the narrative attached to 'abnormal' STIs conformed with the moral discursive construct of pollution discussed in Chapter One, specifically 'polluted' womanhood. The sex worker did not perceive abnormal STIs as a common occurrence. They believed that catching any of these infections meant that sex had been sold without using a condom or without properly checking the physical condition of the client. Unsafe working practice was linked to deviancy and if an infection ensued then sex workers had only themselves to blame. The sex workers believed the barrier they maintained between themselves and the client had been broken; bodily fluids had been exchanged (McKeganey and Barnard 1992). For instance Dee had caught Herpes from a client whom she presumed had a cold sore. She admits that she had been totally ignorant of the fact that cold sores posed a risk to her sexual health.

"I went to the GU clinic...they said the big H word, frightened me to death, felt filthy dirty, felt really terrible" (Dee).

Chlamydia and Hepatitis B were not thought of with the same negative connotations as other STIs. However, it must be noted that Chlamydia and Hepatitis B are relatively new infections within the area of sexual health work, education, moral and medical discourses. Consequently sex workers appear not to be as aware of the long-term consequences of both infections, if they are left untreated. Being so new to the arena, Chlamydia and Hepatitis B did not appear to have the historical symbolic association of 'pollution', immorality, contagion or death attached to Gonorrhoea and Syphilis in the late 1800's and HIV/AIDS in the late 1980's. That said, STIs did not always necessarily relate to sex workers' involvement in prostitution. The usual strategies and techniques for avoiding STIs did not always apply to partners or boyfriends. As previous studies have illustrated, sex

workers do not use condoms in their private sexual lives (Matthews 1990; Day and Ward 1990; McKeganey and Barnard 1996). All incidences of Hepatitis B, Gonorrhoea, Crabs and Chlamydia, mentioned by Queenie, were traced to partners or ex partners. The narratives illustrated that for some sex workers STIs caught via a partner did not have the same moral and medical discursive constructions of pollution, stigma or safety as those attached to being 'physically polluted' by a client.

Some of the sex workers perceived HIV/AIDS as presenting a huge risk to their health, but for others the risk of catching any STI held the same fear. Risks to their personal sexual health were increased by and linked to the actions of others. Nonetheless, to be able to work,

> *"...you can't worry about STDs in this job you really can't, you'd be permanently scared stiff"* (Katrina).

2. CLEANLINESS AS PROTECTION - INFECTION AS PUNISHMENT

Sex workers claimed that cleanliness of both sex worker and client was paramount in protecting the sex worker from STIs. Thus the narratives contradict the moral discursive construct of sex worker as a 'pollutant' and confirm the sex worker being 'safe from pollution' as discussed in Chapter One. If unclean, in either their personal hygiene or sexual practice, the sex worker stated they could become infected. Infection caused by uncleanliness was therefore constructed as punishment. Sex workers believed that risks to their sexual health were diminished if the clients looked clean, not only in terms of being 'free from infection' but also being hygienically clean. Katrina was adamant that if a client visited the parlour and he was *"filthy dirty"* then he would be made to have a shower or he would not be allowed in. If after the shower dirt was still present underneath his fingernails then vibrators would be used to protect sex workers against infection. Those working privately perceived STIs to be a major health risk for sex workers working from the streets (Maher 1996), conforming with the discursive construct of 'polluted womanhood' for certain types of sex work.

Sex workers understood that if they were hygienically clean and 'safe' in their working sexual practice, their sexual health would not be at risk. For Katrina hygiene was extremely important, *"I mean I'm in and out of that shower at least five times a day when I'm working".* Kitty reported washing before and after a client with anti-bacterial soap and cleaning her

teeth. Washing before and after a client was much more difficult for those working from the streets. For Dee whether the client looked clean was not a factor to be considered when negotiating a *"safe"* sexual exchange. She explained regular clients had tried to have unprotected sex with her because she looked clean but as she went on to say,

> *"...I've said you don't know that, you can't see viruses, you can't see diseases, you can't see any of those things, it doesn't matter what a person looks like"* (Dee).

Interestingly, when sex workers' sexual health was threatened by clients who attacked them, some would conform within their narrative with medical discourse and the discursive construct of 'sex workers as a physical pollutant' in an attempt to protect their sexual health. For instance May said the following to a rapist,

> *"...as we're working girls how do you know we're clean, we might not be clean, are you willing to put yourself at risk?"* (May).

Sex workers defined risk as undertaking unsafe, unclean sexual practices. They believed that if an infection developed, then the sex workers had only themselves to blame. The ensuing infection was constructed as punishment for irresponsible sexual behaviour. Risks to their sexual health in relation to STIs, whether the result of responsible behaviour and sexual cleanliness or irresponsible behaviour, are associated with the practice of unsafe sex. They talked about unsafe sex in relation to rape and condoms splitting.

3. UNSAFE SEX

Sex workers understood unsafe sex in relation to the non-use of condoms and condom failure (Cusick 1998). Sexual health was recognised as at risk during the act of rape. The risk of rape was identified as a major concern for sex workers working from the streets, and reflected in the number of incidences they reported, illustrating 'diminished rights' and issues within 'power relationships' discussed in Chapter One. Babs recounted an incident of rape and another of sexual assault, which happened to her during the twelve months prior to the interview. She described how the rape had occurred when she had been taken to a client's house. The rapist had held her prisoner, at knifepoint, for five and a half hours, during which time he raped her. Although she acknowledged she had no control over the sexual act she felt great shame, not because of the rape itself, but that she had been unable to make the rapist wear a condom. After the rape, Babs reported attending the local

hospital to seek medical care for cuts and bruises. She was concerned that the attack had exposed her to sexual infections. However, she did not tell the doctor the full story of the rape.

> *"I didn't tell them the truth because he did sex without a condom and I was so ashamed of that I didn't tell the doctor up there I said it was French without the condom because I was too embarrassed"* (Babs).

A few sex workers reported clients tried to remove condoms during the sexual act. Sex workers considered clients who offered extra money for sex without a condom were a risk to their sexual health (McKeganey and Barnard 1992). One described being offered £100, another had been offered £500, but according to sex workers it could be as little as £10. Katrina believed that due to *"smackheads giving up hope"* and their desperation for drugs, drug addicted sex workers would willingly practice unsafe sex for an extra £10 as it equated to an *"extra fix"* (Vanwesenbeck et al 1994; Gossop et al 1995). For Abby lack of experience, the need for money and the numbing effects of drugs all combined to create a situation that she acknowledged put her future sexual health at risk.

> *"[W]hen I was a bit younger, obviously you get paid more for going without a condom. It would only happen when I was really off my face and didn't know what I was doing really"* (Abby).

Abby was the only sex worker who admitted to undertaking irresponsible sexual behaviour. For the sex workers, admitting to having unsafe sex for more money was extremely difficult, even though at the time of the sexual exchange they were in a desperate financial situation, were not fully aware, or did not care about their well being. Sex workers' narratives confirmed the negativity within the moral and medical discursive constructs of pollution (e.g. 'polluted' womanhood), stigma (e.g. of infection) and safety (e.g. decreased due to irresponsible behaviour) as discussed in Chapter One. The affects of these constructs meant the disclosure of having unsafe sex was framed within feelings of guilt and shame. Although not mentioned by sex workers, the negative feelings attached to disclosure may have been a consequence of finding the interviewees via a sexual health outreach project. Sex workers appeared well rehearsed on the 'safer sex message', did not want to 'get the sexual health outreach workers into trouble' and as I had approached them via sexual health outreach they assumed I was only interested in matters relating to sexual health, specifically controversial issues (e.g. HIV). These negative feelings were harmful, which

sex workers felt were produced and re-enforced by non-sex workers' negative image of prostitution.

For Fiona personal use of condoms at work was particularly important due to the perceived irresponsible sexual practices and drug addiction of sex workers working from the street, illustrating sex workers working in parlours identified themselves as both different from and superior to sex workers working from the streets. The parlour working sex workers believed the client was not to be blamed for spreading infection, the street working sex worker was constructed as a 'physical pollutant' of the general population, family and womanhood. According to Fiona clients could have unprotected sexual intercourse with *"dirty"*, infected sex workers from the street, catch an infection and the next contact he has with sex workers could be in a parlour. The health of the *"clean"* sex worker in the parlour would then be at risk, unless she ensured at the very least the use of a condom.

> *"They can go and pick someone up off the street, they could pick someone up with a drug habit so you have to be that bit more careful because a lot of them, the youngsters I know for a fact don't use condoms"* (Fiona).

A practical problem that sex workers talked about was unsafe sex as a result of a condom splitting. Five mentioned using two condoms during sexual intercourse, to protect themselves if one of the condoms split. Some reported condoms never split and others stated condoms rarely split. For Diane, with one client, condoms split regularly, nonetheless, she believed the client to be harmless as he was a regular and he *"looked clean"*. Diane perceived him as posing no risk to her sexual health.

Once a condom had split the sex workers believed the barrier between their body and the client's was broken (Day and Ward 1990). The client's sperm makes contact with the sex workers body and it is then, according to some sex workers, the sexual act becomes dirty. Even with the albeit rare possibility of the condom splitting, the majority of sex workers did not mention pregnancy as a risk to their sexual health. Of the few who did, some went to great lengths to ensure pregnancy would not be a problem for them, for instance using several methods of birth control at once. Even when condoms split the health risk to sex workers was linked to infection, not unintended pregnancy. Condoms were heavily associated with the risk of STIs but not pregnancy. Interestingly many of the sex workers reported using condoms but no other form of contraception in either their working or their private lives. The irony that rapidly becomes apparent when examining how sex workers

talked about sexual cleanliness is that the very strategies used to protect themselves actually increased their health needs (e.g. frequent washing and continual condom use caused irritation, thrush and cystitis).

This section has examined how sex workers construct STIs as a risk and a need illustrating conformity with and resistance to dominant discourses and discursive constructs. The development of responsible and irresponsible sexual behaviours relating to 'normal' and 'abnormal' infections underlies the understanding of need and risk respectively.

As already outlined, a sex worker's understanding of responsible and irresponsible behaviours have been influenced by the attitudes and opinions of other sex workers, their own experience of STIs and knowledge gained from the media and medical institutions. STIs are classified as 'normal' as in regular, probable, acceptable with little stigma, and 'abnormal' as in rare, unacceptable and stigmatised. The knowledge/classification has been influenced by the realisation that the STI (in some cases) can prevent them from working (economic process). The concept of 'punishment as infection' has been influenced by their social relationships with other sex workers, supported by moralist media and religious viewpoints.

IV. CONCLUSION

This chapter illustrated sex workers compartmentalised health need and risk as occupational. This has led to the sex worker creating criteria to distinguish between a problem and need. Need implies an action, either self-medication or seeking provision. The sex worker temporally distinguishes between need and risk, as present and past/future respectively. When identified, needs are prioritised as drug addiction, damaged mental health then 'normal' STIs. Mental health needs and problematic drug use (e.g. the more severe the mental health needs, the heavier the drug use) are made worse by prostitution but were not solely a result of prostituting. Violence is prioritised above 'abnormal' STIs as a risk. Working from the streets increased the risks to sex workers' health from violence. Need and risk are made sense of within complex social, economic and welfare relationships. In the context of damaged mental health, sex workers did not discuss the discursive construct of safety in relation to 'pollution' within medical discourse.

The sex workers have constructed behaviours in relation to the sexual exchange and drug use, which can be classified as responsible or irresponsible. These behaviours have resulted in a clear divide between street sex workers and those working from private premises, creating a hierarchical separation. The sex workers working privately perceived their health needs and health risks to be less intense than sex workers working from the street. Irresponsible and responsible behaviours are directed by rules operating under certain conditions limited by specific authorities. An example of this is Abby who was desperate for drugs and had no clean needles, she tried to follow the rule 'do not inject without clean needles', but the psychological and physical withdrawal (i.e. condition) was too strong, causing her to inject ignoring the consequences. If a limiting authority had been present (i.e. Sexual Health Outreach Project worker), clean needles would have been available. These aspects of the construction of need and risk as indicated in each section have specific influences, but generally they are from social relations within the workplace and the constraints of economic processes and poverty. Important others influence their identification of needs.

The construct of pollution has two aspects. The first aspect is that of the sex worker as 'polluting others', particularly observed within the sex worker hierarchy. Understood within irresponsible behaviour is the attitude to 'smackheads' and the use of needles, 'polluting' the sex worker community, specifically the parlour level by those at the street level. The sex worker is a medical 'pollutant' due to spreading infection, but is also a moral 'pollutant' by bringing the parlour sex workers into disrepute, as the whole prostituting community is treated and stigmatised as one. This is continued by other irresponsible behaviour, such as unsafe sex, a case of 'self pollution'. The second aspect, that of the sex worker as 'polluted by others', can be seen in the attitude of cleanliness as protection and infection as punishment exhibited in sexual exchange behaviour. The client is the 'pollutant', but responsibility lies with the sex worker to protect herself. If unsuccessful, infection is the punishment.

The construct of rights is expounded in sex workers need to gain control over the sexual exchange to compensate for the loss of their rights during a past experience. However, the number of incidences of violence illustrates the reduction of their right to be 'safe'. The use of self-harm is a desperate wish for power and control within their lives, in this case the body but expressed under a condition of damaged mental health. They exhibit control in their life predominately in conceptual terms related to work to survive in the lifestyle and

minimise damage (e.g. compartmentalisation and the perception of prostitution as work, and consideration of prostitution as a means of control over their body). Drug addiction and mental health damage severely limit their power to protect themselves during the sexual exchange and from lifestyle health damage.

Stigma is prolific within their lifestyle: Self-loathing resulting in self-harm for what they do, alienated from the non-sex work population, engendering a desperation for belonging found only in the company of others within prostitution and drug use. Stigma attached to drug use from the general public and also from within their own hierarchy towards those who use needles and heroin. Safety is clearly limited within occupational terms, only when a health problem affects their ability to work does it become a health need requiring action, as self-medication or seeking provision. They clearly recognise their mental health and drug addiction needs as they are too strong to ignore. The number of self-medication and risk reduction strategies coupled with the creation of cultural responsible behaviours are strong indicators of their concern to survive. The sex workers narratives illustrate safety as understood within the limits of their world.

Chapter Five will now analyse the way in which service providers construct the health needs of and health risks to sex workers.

Chapter 5

SERVICE PROVIDERS CONSTRUCTION OF SEX WORKERS HEALTH NEEDS AND HEALTH RISKS

In chapter four, it was illustrated that sex workers' construction of health need and health risk was dependent on the ways in which they understood the 'right' and 'wrong' way to behave when working as a sex worker, and was affected by the extent of drug use, mental health damage and their place of work. In this chapter, analysis of the service provider interview material illustrates their construction of sex workers' health needs and health risks is dependent on the remit and speciality of the project, professional ideologies, personal bias, training and the experience of the interviewee. This chapter meets the second objective of the study.

The literature review in Chapter One illustrated that medical, moral and legal discourses are not independent but are shaped by the social variables of professional interests, gender, race and class (White 2002). However, in terms of their impact, professionals participating in these discourses govern sex workers' lives. The service provider does not experience the health need of the sex worker, nor is their own health at risk, but the service provider adopts discursive positions in relation to the sex worker, her activities (e.g. selling sex, illegal drug use) and her experiences (e.g. abuse, violence, infection, poverty). The construction of sex workers' health needs and health risks are thereby constrained by broader issues and processes as will be illustrated in the following chapter, which examines, how any particular health service provider understands their service, compared to other health services in the area, their perceptions of the problems of sex work and illustrating conformity with and challenges against the discursive constructs of pollution, safety, stigma, rights and power identified in Chapter One.

Possessing professional qualifications raises the service provider to a level of importance both within their own specialisation and among other professionals and groups. Qualifications increase an individual's level of power and authority and acceptance by others of that authority. Authority in turn brings responsibility and accountability to the client, other service providers and associated professional bodies. Authority provides the service provider with a level of power, which enables the professional to construct the health needs

and health risks of others. Despite possessing qualifications a service provider is someone whom the sex worker believes has little or no experience of the risks within their lifestyle. The importance of a service provider for a sex worker is in the real help that the service provider can give, and not the qualifications the service provider possesses. The following quotation clarifies how sex workers have described some service providers, *"...read a book a few times, what do they know about my life"* (Sexual Health Outreach Worker B). It not only illustrates the disregard that they feel towards some of the service providers but also the problematic relationship that they have with some of them.

The interviews explored how the service providers identified the health needs of, and risks to, the sex workers they came across during the course of their work, or those the service provider had heard about, either from other sex workers or other service providers. Service providers made no clear temporal distinction between health need and health risk as had been made by the sex workers interviewed. For instance service providers identified STIs as both a present health need and a past and future risk to health. Nevertheless health need continued to imply a requirement for some form of action (i.e. service provision) and health risk implied the context within which sex workers worked. For instance damaged mental health implied a health need requiring support, therapy and medication, whereas damaged mental health was also considered a risk to health increasing the sex worker's vulnerability to drug use, her inability to negotiate safer sex and mitigate violence. Blame and weakness associated with irresponsible behaviour constructed and indirectly conforming with moral discourse (i.e. the constructs of safety and stigma) by the sex workers interviewed were not mentioned by any of the service providers. The concept of survival was used to explain the actions of some sex workers. Service providers believed sex workers were working to survive in an environment within which they knew no other lifestyle, and believed they had limited alternatives and few rights. To continue to sell sex, particularly working from the streets, service providers believed took a great deal of courage.

Service providers constructed the health needs and health risks of sex workers within a medical discourse incorporating biomedical and social models of disease (White 2002). The biomedical and social model encompassed illegal and legal drug dependency, mental health needs, violence and sexual health needs. These were the same health concerns identified by sex workers but categorised and prioritised in different ways as need and risk. The following sections of the chapter will explore the implications of the health care model

used, professional ideologies and personal bias and provide an insight into the service providers' constructions of the problems of prostitution in terms of need and risk.

I. MEDICAL DISCOURSE - NEED AND RISK

Professional understanding of the health need and risk of sex workers were constructed within a medical discourse relating to biomedical or social models of disease. To reiterate, the biomedical model is the traditional, accepted way of thinking about disease and infection giving authority to professionals who control medical knowledge. In comparison, the social model constructs an approach that takes into consideration social, political and economic factors, which not only cause the health need or risk to health, but also affect the treatment given, and how the treatment is tolerated or adhered to by an individual. This section provides an overview of the models and the contextual constraints relating to the sex worker population. These issues and influences are considered in detail throughout the chapter.

1. BIOMEDICAL MODEL

The biomedical model as outlined in Chapter Two identifies germs, viruses or bacteria causing health needs as located in the individual body. In the theoretical framework discussed in Chapter One, health is described as the absence of biological abnormality, therefore illness is the presence of a biological abnormality (Field 1993). Disease is treated as having an objective and scientific existence rather than directed by the subjective feelings and interpretations of the individual with the health need. The service providers are able to control and define certain aspects of the 'patient's' life (Goffman 1961). Disease is problematic and requires medical intervention.

Medical treatments obviously affected the way in which the service provider defined illness and infection. The clinical services (i.e. statutory) in Old Port had greater potential than the voluntary services to treat the health need, medically or pharmacologically. The construction of need and risk based on the biomedical approach to care that the service providers took was modified within the limits of the service speciality and remit. For instance the GU Health Adviser practising Desensitisation and Reprocessing (D&R) could only treat patients whose initial contact was sexual health. Additionally the D&R treatment was an extension of the traditional biomedical remit of GU. D&R involved two to three

sessions within which the patient repeatedly talked about a traumatic experience until they could retell it without severe negative reactions (e.g. fear, anger, blame, disgust).

In the case of drug abuse the statutory drug project had the local health authority licence and the qualified professionals able to assess and prescribe substitute medication. The power that biomedical service providers possessed, changed the dynamics of the relationship with service users. As the only community based clinical service in the city, it meant the service providers were working with a wide range of people with complex health needs and risks to health. The decision of whom to choose for treatment from the drug users referred, in order to reduce harm caused by drugs misuse was made within an environment of

> "[c]*omplex pregnancies, people using a lot of different drugs, high benzo use, chaotic living, sex work, complicated mental health issues and physical health issues*" (Locum Drugs Worker).

As the prime concern identified by service providers is the treatment of infection and reduction of drug use, the biomedical model gives priority to the treatment of the sex worker's body, not her lifestyle. The discourse analysis identifies that there exists wide variation between, and differing understandings of, lifestyles and life experiences between medical professionals who prescribe treatments and care, and sex workers who are the objects of their control.

2. SOCIAL MODEL

Within the social model, the construction of health needs and risks does not rely solely on any particular professional definition. Instead it approaches the issue of health from a holistic perspective. As outlined in Chapter Two and Bradshaw's (1994) social perspective on health need the person is treated as a whole, rather than just the symptoms of the illness being treated (Nettleton 1995; White 2002). In the theoretical framework in Chapter One illness is described as being caused by a much broader range of factors rather than merely biological pathogens. Within this model the multifactor causations of most diseases permits an understanding in which indirect and direct effects contribute. Indirect effects occur under certain social conditions within which the individual and harmful physical or biological factors come into contact (e.g. work hazards, environmental pollution, water-borne organisms). Alternatively, social factors may have a direct effect, such as when something in the social environment causes illness. Direct effects are more controversial,

as illness is seen to occur due to a non-physical hazard. So, for instance, non-physical influences would be direct, stressful events such as bereavement. Non-physical influences would also include the social factors that increase an individual's vulnerability, such as poor social integration (Durkheim 1933), poor social support and negative life events (e.g. unemployment) (Taylor and Field 1993; Armstrong 1994).

The majority of service providers defined the health needs of sex workers as illness or infection. Only one interviewee queried such a biomedical definition, including in their reply the negative consequences of poverty on health.

> *"I suppose it depends on how you define health, in terms of illness or more general stuff. I think a lot of the women are on low income I would imagine that would equate to poor diet. All smoke, a lot of them drink"* (Sexual Health Outreach Worker A).

But the interviewee then continued to define health needs in biomedical terms. So even within the social model of disease, health needs were, to a point, primarily defined and accepted as a biomedical problem. Although the construction of need and risk was primarily based on the individual's ideology (i.e. social model of care) it was modified within the limits of the service speciality and remit. For instance the Locum Drugs Worker was a social worker but worked within a service within which priority was biomedical.

The next section will examine how the role of the service provider, and how the service providers' professional ideologies and personal bias, are central and influence the process of constructing sex workers' health needs and risks.

II. PROFESSIONAL IDEOLOGIES AND PERSONAL BIAS

The professional association or body with which an individual is associated governs professional ideologies. Professional associations are historically connected with medical professions and dictate a certain way of thinking, or particular ideas, (e.g. equality, confidentiality) that direct the practice of the professional. Personal bias is an individual predisposition, directed by personal subjectivity within clear and recognised boundaries. Bias can change depending on the social and professional situation and what is thought to be a 'popular' view on an issue.

Differences in professional ideologies affect the assessing and prioritising of health needs and health risks. Due to their diverse theoretical and practical training, service providers from different disciplines (e.g. medicine, psychiatry, social work), discussed different perceptions and interpretations of illness, disease, need and risk. Depending on the severity of the need and risk, either the biomedical or the social model of disease takes the lead in the assessment and construction. The type of model used, whether biomedical or social, dictates for instance the reasons given to why a particular type of risky behaviour is undertaken. For example the reasons given for drug usage within the biomedical model might be chemical dependency, whereas in the social model drug usage may be explained as blocking the traumatic memories of previous abuse and experience of current sex work.

The following quotation illustrates how the Locum Drugs Worker clearly differentiates her construction of health needs from those of other members of the project, who have biomedical training.

> *"I think that* [project name] *might have a policy but different workers do it* [*define health needs*] *differently. I think that's human, I'm not a nurse, I'm not a doctor, I'm a social worker by qualification so I'm a bit different"* (Locum Drugs Worker).

The Locum Drugs Worker explained how work experience positively biased her working practice towards sex workers. When she could she reported prioritising treatment for sex workers after observing them in drug induced states trying to pick up clients. Her narrative confirmed the medial discursive construct of safety discussed in Chapter One. Her experience provided an understanding of their health risks in lifestyle terms; the desperate situations in which she believed sex workers exist, due to poverty, violent clients and pimps, compounded by heavy drug usage. She had previously worked in an area in London renowned for sex work but in the relative *"safety"* of a centre.

> *"I used to work in London in a crisis intervention hostel, short stay centre, where there was a lot of young people working on the rent scene, Piccadilly, it was horrendous, just awful but I never really touched it* [the danger and desperation] *until I started going out with* [sexual outreach]" (Locum Drugs Worker).

Some service providers mentioned that 'other service providers' allowed negative, moral personal bias to influence their construction of sex workers' health need and risk. The next section discusses how professional ideologies and personal bias were believed to affect

the way in which service providers classified sex workers' health need and health risks as either the 'same as' or 'different from' non-sex workers, and 'differences between' sex workers. This section will also clarify how the discursive construction of the sex worker as morally 'polluted' as discussed in Chapter One has influenced the construction of need and risk.

1. SEX WORKERS 'THE SAME AS' NON SEX WORKERS

Three service providers constructed infection and disease of sex workers within notions of the similarities between sex workers and non-sex workers. Some service providers described the sex worker as an 'ordinary' woman (McLeod 1982; O'Neill 1997). They maintained within agreed treatment plans sex workers had the same rights as any other individual with the same or similar health needs, to receive treatment in order to reduce health risks. Service providers believed sex work was a valid 'choice' of employment between consenting adults, contradicting the moral discursive construct of pollution and stigma. The Consultant Psychiatrist believed some sex workers were,

> *"...quite sanguine about selling sex, comfortable to be earning money in this way and see it as just a job as any other"* (Consultant Psychiatrist).

This illustrates the belief that some sex workers accepted the lifestyle, as did the service provider. Their health needs were explained as a resultant effect of other life experiences or lifestyle 'choices'. Two service providers identified the level of mental health need and the incidence of STIs did not appear to be higher among sex workers when compared to non-sex workers.

> *"I don't think there is a higher or lower incidence* [of mental health problems] *among that group than other groups of people with drug dependency problems"* (Consultant Psychiatrist).

> *"I wouldn't say that working women's health problems are any different to non-working women's problems"* (Family Planning Nurse).

On seeking help for their drug use sex workers were perceived to be categorised the same as non-sex workers, challenging moral and medical discourses and discursive constructs of sex worker as 'other', outlined in Chapter One. Sex workers were identified as no more morally or physically 'polluted' or a 'pollutant' than drug-using non-sex workers. Regardless

of whether or not they sold sex, women as a whole were identified *"...as being emotionally stronger than men who are less likely to cope at an earlier stage..."* (Senior Drugs Adviser). So by the time women, either sex workers or non-sex workers, received treatment they had reached a state of complete chaos, as emphasised by the Senior Drug Adviser *"...lost the plot mentally and physically"*. The only identified difference was the way in which women financed their drug habit, not in the resultant health needs. As with sex workers, service providers believed non-sex workers relied on drugs due to the necessity to block self doubt, self-loathing or to forget bad experiences.

> *"[P]eople that use substances problematically are usually doing it for a reason"* (Senior Drugs Adviser).

These service providers treated sex workers as individuals with a drug dependency; sex work was a secondary issue. In this instance their involvement with sex work was only one aspect of their lives. Being a sex worker was only part of their identity. Being a sex worker was the woman's whole identity on contact with the Police Liaison Officer. It was the factor that dictated the service providers' behaviour towards sex workers. As a sex worker she was targeted as she was breaking the law; if she had not been a sex worker the Police Liaison Officer would not have contact with her.

Service providers constructed sex workers' health needs, associated with health promotion issues (e.g. diet, smoking, drug and alcohol use), within the same context as non-sex workers, from the same or similar deprived social and economic backgrounds. Nonetheless, the lifestyle of non-sex workers was described by some service providers by using the notion of 'normal', as in typical, natural and ordinary. The Family Planning Nurse, in using the notion of normal to describe the lifestyle of non-sex workers, implicitly implies abnormal to describe the lifestyle of sex workers. Sex workers were understood as abnormal due to the lifestyle they led (e.g. selling sex, drug use). Therefore, once notions of normality and abnormality are used sex workers are constructed and treated differently. The use of 'abnormal' introduces ideas of deviancy, immorality and unnaturalness, contradicting the recent discursive constructs of pollution and stigma where the sex worker was not generally considered in these terms, as discussed in Chapter One.

Three service providers perceived sex worker needs to be the same as non-sex workers in respect of damaged mental health, drug addiction and incidence of STIs. The Consultant

Psychiatrist's and the Senior Drug Adviser's constructions were influenced by the experience of treating sex workers within a client group of severe drug dependent individuals with high levels of need and risk. Within these terms of reference the sex worker would appear the same. With respect to STIs the Family Planning Nurse had no direct contact with sex workers, her knowledge of their needs and risks was second hand and uncertain.

2. SEX WORKERS 'DIFFERENT FROM' NON-SEX WORKERS

As will be shown, some service providers' understanding of health needs of sex workers implied differences between them and other women who were not involved in sex work. Difference between sex workers and non-sex workers was explained within constructions of vulnerability and desperation in relation to sexual health and drug use and not the sex worker as a 'pollutant'. For the Locum Drugs Worker, experiences on the street with sexual health outreach, combined with social work training had shaped her thinking about the needs and risks of sex workers. Although she categorised drug use within a biomedical model of disease in which the problem would be one of clinical need she also constructed sex workers' needs and risks in the context of the discursive constructs of reduced power and limited rights. Reduced rights and power illustrated by the incidence and severity of violence when working from the streets, and as a result of drug use when sex workers were incapable of reacting properly to immediate danger (e.g. kidnapping, violence, rape, robbery). The Locum Drug Worker understood that not only did sex workers have a higher risk of physical and psychological damage but they were already severely psychologically damaged; in her narrative she resisted the perceived negativity of moral discourse.

> *"The women who are working are actually hurting more because often women do have serious sexual abuse histories, violent histories around men, thinking they are not worth anything and are used to men taking advantage of them"* (Locum Drugs Worker).

Other service providers located sex workers as vulnerable when they stopped taking the drugs. They understood sex workers then had to cope with negative feelings in relation to rape and abuse but also the damaging psychological effects of selling sex. The drugs temporarily subdued the problem.

The Locum Drugs Worker identified place of work and the way in which sex workers earned money to finance the drugs as issues which made them more at risk than other drug users.

This risk was not constructed as the sex worker being the 'pollutant' but as the sex worker being at risk from being 'polluted'. According to service providers this makes sex workers different from non-sex workers who finance their drug usage through activities such as stealing and shoplifting. Although these activities have legal penalties they do not hold the same health risks or health needs that arise from selling sex (e.g. STIs, damaged mental health). Some service providers perceived sex workers to be *"...desperate...they need to earn money very badly"* (Senior Drugs Adviser). Service providers described desperation for money made sex workers different from non-sex workers. The interviewees pointed out that, combined with the way sex workers finance their drug habit, they use drugs in different ways. It was maintained sex workers take drugs to enable them to work and cope with the psychological trauma of sex work. As such, different drugs are taken at specific times to give them the courage to go to work, to enable them to stay at work and to relax after work.

> *"They probably use more drugs in the sense that they will use some crack or speed to go to work, to keep them at work. They will use some Valium after work to come down and they probably have a heroin habit, that is why they have to work and they will probably go for a couple of drinks with the punters to keep warm. So they might use a range of drugs because the drugs have specific functions"* (Locum Drugs Worker).

Analysis of the service provider discourse indicates that generally the service providers' viewpoint is that selling sex puts sex workers in a different category not only to other women, but, if using drugs, other drug users. Difference was constructed in relation to concerns for the personal safety of the sex worker and not as the sex worker as a risk to the safety of the general population, family or womanhood (i.e. confirming the current medical discursive pollution construction). Service providers' narratives generally resisted the perceived negativity of 'other' contained within moral and medical discourses discussed in Chapter One. Risks to their health associated with selling sex and drug use are apparent in the following quotation. The Locum Drugs Worker had observed sex workers,

> *"...off their faces getting into stranger's cars, when you actually see the men and you are out there at night and you are scared...and it's raining, it's pouring and it's cold..."* (Locum Drugs Worker).

Difference from other women was also constructed in relation to notions of sexual health and cleanliness. The Family Planning Nurse believed,

"...the majority of working women are very conscious of their own sexual health and use of condoms" (Family Planning Nurse).

However, she continued by claiming sex workers were at a higher risk from STIs, unintended pregnancy and cervical cancer. The GU Senior Health Adviser indicated sex workers were *"relatively free"* from STIs, although chlamydia was becoming more common. Such empirical observations allowed her to make a clear distinction between what she believed was the majority of sex workers' safer sexual practice and non-sex workers, who for example, go clubbing on a Saturday night and have unprotected sex with different men. The GU Senior Health Adviser identified and constructed the non-sex worker as the physical and moral 'pollutant' not the sex worker, resisting the moral discursive construction of pollution and stigma attached to sex workers discussed in chapter One. Difference, in this case, was explained to be not only due to the need of the sex worker to protect her own health but also her *"clean"* reputation, and keep her clients, so her income.

Negative life experiences, long connections and relationships with statutory organisations (e.g. the social services, the police), were also identified by the service providers to enable them to differentiate between sex workers and non-sex workers. It was claimed that experiences (e.g. being in care, numerous arrests, their children being taken into care) and numerous prior treatments (e.g. counselling, psychotherapy) had made sex workers suspicious of statutory authorities and perfect the behaviour of internalising thoughts and feelings. Sex workers were believed to be less open with, and have less trust in, service providers than non-sex workers.

The construction of sex workers' need and risk as different from non-sex workers' was founded within an ideology of biomedicine extended by experience and observation including social model attributes. Sex workers were considered to be different due to their intensity of need and risk, coupled with greater incidence of psychological damage and drug addiction resulting in reduced rights and power. For STIs the sex worker was not constructed as the 'pollutant'. Service providers considered previous stigmatising experiences of statutory organisations increased psychological needs and risks.

Connected with the idea of sex workers as different from non-sex workers was the use of historical notions attributed to 'other' service providers, of the sex worker as a physical and

moral 'pollutant' constructed within medical, moral and legal discourses. This discursive construction of pollution will now be examined.

3. SEX WORKERS AS MORALLY 'POLLUTED'

Within their own assessment of health needs and professional ideologies, it became apparent from the narratives that service providers resisted and challenged the discursive construct of pollution encompassing moral and physical contamination within medical, moral and legal discourses. However, as will be illustrated by the following quotation, when the interviewees discussed other service providers, professional ideologies were described as corruptible, affected by personal bias, containing moralising judgements and guided by the perceived negativity of the moral discursive constructs of pollution, stigma and safety discussed in Chapter One.

> *"I think because we are talking about sex and drugs it's about individual professional morals themselves, you can't always hide behind professional training, it doesn't mean that your own values don't come out"* (Locum Drugs Worker).

Personal bias was considered by the interviewees to be a strong influence on their professional ideologies. Other service providers were reported as being influenced by personal morality regarding ethical issues of selling sex, as well as their belief that drugs and alcohol are taken out of choice. Moralising constructions of the sex worker as sinful and evil were explained as particularly common if an *"innocent"* victim was identified, for instance, an unborn child. Not only was it believed that sex workers were acted upon as 'polluted' but the notion of an innocent child becoming infected due to the risky behaviour of a mother continued the specific form of the 'polluted family'. Accusations of the use of negative bias (e.g. drug use was a life style choice) were directed by the service providers at the more traditional biomedical services (e.g. midwifery) that did not come into frequent contact with sex workers. If sex workers were also dependent drug users or vice versa they were constructed as 'doubly polluted'.

The resultant belief, that contamination culminating in health needs was self-induced and a product of immoral conduct (e.g. due to taking drugs or selling sex), was explained to influence some traditional service providers' willingness to make contact with sex workers even before carrying out an assessment of the health needs of and health risks to sex workers. Personal bias affecting issues around control of infection, 'polluted' family and womanhood and the extent of personal responsibility, examined in Chapter One, was

therefore perceived as dictating the assessment of health needs, as is illustrated in the following quotation,

> *"[t]hey* [drug users] *are a client group who often other people don't want to work with so they are hard to share"* (Locum Drugs Worker).

4. 'DIFFERENCES WITHIN' SEX WORKERS

Sex workers in 'Old Port' were not believed to be a transient population. They did not tend to travel outside or come into 'Old Port' to work, a situation explained by the service providers to be partly due to the geographical location and economic context (e.g. poor transport links, long distance to larger conurbations). As such, sex workers were described as staying in the same work situations either working from the street or working privately. Therefore the population was described as static, which the service providers believed allowed them to get to know, and build up a relationship with the sex workers and be more specific in their construction of individual need and risk and the inherent differences. In this instance familiarity within the relationship reduces conformity with and increases resistance to the perceived negativity contained within moral, medical and legal discourses.

Analysis of the narratives indicates service providers identified difference between sex workers in terms of the classification of their drug use and the severity of mental health damage. Difference also related to the clear divide identified by service providers between those sex workers who work from the streets and those who work privately. Problematic drug use, primarily the use of needles, was constructed as a need and risk for sex workers on the street. Injectable drug use was not understood as a need or risk for sex workers in parlours because service providers believed sex workers could not work in parlours if they injected drugs. Nonetheless, service providers identified alcohol to be the drug of choice for some sex workers in parlours. Sex workers working from the street were reported to drink alcohol but it was not their main drug of choice.

Sex workers taking injectable drugs and working from the street were understood to be more vulnerable to infections and violence than those working privately. Service providers considered sex workers working privately were less psychologically damaged, reducing the need for drugs and increasing the belief of sex workers in their own self-worth so increasing behaviour that protected their health. However, this may be due to the fact that they appeared on the surface to be more capable due to their non-use of injectable drugs.

> *"They* [sex workers working privately] *appear to look more together, they appear to have a bit more money, they commute a little more so I suppose to do that you would have to say that things are a bit better for them but having said that I've met some terribly emotionally damaged women too"* (Sexual Health Outreach Worker A).

The GU Senior Health Adviser identified sex workers who visited the clinic as predominately working from the street, and therefore could not comment in depth on the off-street workers. The service provider believed sex workers working as escorts attended private hospitals or clinics or paid to see GPs privately.

> *"I think we've always seen less of the ones who work the high class hotels I think they tend to do things slightly differently"* (GU Senior Health Adviser).

Service providers' constructions were affected by the population section who used their service and the knowledge of the sex workers working location. They considered private sex workers to have less incidence and severity of need and risk, specifically problematic drug use and mental health damage.

III. NEEDS AND RISKS OF SEX WORK

This section explores the way in which service providers' experiences and observations from contact with, and treatment of sex workers has influenced the understanding and construction of the sex worker's lifestyle and the consequential need and risk, thereby completing the second objective of the study. Service providers understood the needs and risks of sex workers as damaged mental health and violence interconnected with problematic drug use and STIs with no clear temporal distinction. The following sections will discuss how service providers made sense of these needs and risks.

1. DAMAGED MENTAL HEALTH

The service providers identified damaged mental health as a major need and risk for sex workers. The primary mental health needs were identified as learning difficulties and personality disorders, exacerbated by sexual abuse and selling sex. The Police Liaison Officer claimed *"...a lot of them are vulnerable due to being a lot lower in years, mentally"*. A number of sex workers were also identified as self-harming (e.g. cutting themselves, eating disorders). Service providers believed learning difficulties limited sex workers' understanding of harm-reduction strategies, primarily negotiating the sexual contract, and

made them vulnerable to manipulation by clients therefore putting themselves at risk from unsafe sex and violence. The psychological risks attached to selling sex were understood as depression, low self-worth and suicidal thoughts. It was explained that mental health damage attracted a label with negative consequences (e.g. stigma, alienation) especially when terminology such as 'mad' was used along with sex and drugs in the service providers' discursive framework. For instance "*...people will self medicate madness with drugs but drugs can also make you mad*" (Locum Drugs Worker).

Service providers reported prioritising sex workers for drug stabilisation by their vulnerability to risk caused by their mental health state, "*...people have mental health problems but people feeling suicidal is a mental state*" (Consultant Psychiatrist). A poor mental state combined with drug use was explained to result in sex workers becoming very unpredictable and vulnerable. The risk was constructed as potential harm to the sex worker and not to the general population, family or womanhood, confirming the medical discursive construction of safety in keeping the sex worker 'safe' and contradicting the moral construction of the sex worker as 'pollutant' as discussed in Chapter One. As the Sexual Health Outreach Worker (B) indicates, they were unsure about the exact relationship between mental health and problematic drug use.

> "*I don't know what comes first, whether it's substance use causing mental health or substance use is exacerbating any underlying conditions of mental health*" (Sexual Health Outreach Worker B).

Other service providers possessed biomedical ratified knowledge to enable them to diagnose the mental health need. These services possessed a greater depth of understanding in relation to diagnosis. Borderline personality disorders and Post Traumatic Stress Disorder were described by the Consultant Psychiatrist as a personality who

> "*...breaks down under stress...likelihood of impulsive self harm behaviour, rapid changes of mood, psychotic episodes either as a result of stimulant use or as a result of stress that recalls the actual trauma*" (Consultant Psychiatrist).

Health need in the form of depression is linked by service providers to feelings of low self-worth. According to the service providers low self-worth underpins the whole lifestyle of sex workers, leading them to believe they are not deserving of any other lifestyle, accepting the associated needs and risks to health and deepening the depression. This viewpoint

conforms with the discursive constructs of diminished rights and issues within power relationships, specifically the social vulnerability of sex workers. Service providers found it difficult to ascertain whether depression was a result of sex work, or due to previous traumatic life experiences. It is not only selling sex but also the sex worker's whole lifestyle (e.g. emotionally and physically abusive relationships), which contribute towards her mental health need and the health risks.

2. VIOLENCE

Service providers identified violence as a common occurrence in the sex worker's lifestyle. A Sexual Health Outreach Worker (B) claimed, *"...probably most women have had at least one incidence of work-related violence"*. They considered the sex worker underplayed violence, portraying it as being part of the whole picture of sex work. Service providers' narratives illustrate that due to negativity within moral and legal discourses some sex workers accepted the discursive construct of pollution and 'polluted' womanhood and therefore believed they were deserving of violence. Service providers identified clients as the main perpetrators of violence. A Sexual Health Outreach Worker (B) stated, *"...violence from outside, you know principally with punters"* and this was confirmed by Sexual Health Outreach Worker (A), *"[v]iolence from clients, I think is a huge risk"*. Incidences, type and severity of violence were described as being dependent on where sex workers worked, how they chose their clients and how able they were to choose because of their need for money and their ability to accurately gauge the clients character or intent. Violence around drug issues particularly in relation to retaliation was explained as increasing. Not only in terms of numbers of attacks but also the severity of the attacks. For instance one of the sexual health outreach workers (B) had spent two days before the interviews supporting a sex worker who had been subjected to a drug related violent attack with a machete.

> *"[W]ithout judging the drug using community, something that is increasing is violence, whether it be around taxing, whether it be around domestic stuff but that to be fair is across the board. I think the level of violence is increasing and it's not just the level it's the number of attacks, that actually what happens in the attacks seems to get more traumatic, which is getting very worrying"* (Sexual Health Outreach Worker B).

For service providers the ability of sex workers to reduce the risks of violence was linked to their mental health, drug usage and the financial situation of the sex workers. Violence was understood in terms of victimisation and desperation. Service providers identified sex workers as victims due to their lack of power both within the home (e.g. children in care, poor partner relationships, lack of options) and while working. Their narrative conformed

with the legal discursive constructions of power and rights, specifically issues around consenting adults, diminished rights, social and economic vulnerability. They believed desperation for drugs and therefore money led sex workers to undertake behaviour that is a risk to their health.

> *"They are in desperate need of a fix and think well I can get 2 bags for that money"* (Police Liaison Officer).

The service provider also constructed the sex worker as 'desperate' when working in a drug-induced state to earn money for more drugs (e.g. addiction). They believed that due to financial desperation and lack of control within the sexual exchange, situations occurred when sex workers would provide unprotected sex, either when they had been offered more money or had been physically forced into it. For a few service providers, including the Police Liaison Officer, incidences of violence correspondingly increased with an increased police presence. The narratives confirmed the legal discursive construct of safety as discussed in Chapter One, legislation that decreased safety of the sex worker with the potential to increase 'pollution'. Due to the increased fear of arrest and fewer clients, sex workers were not believed to take the same care or consideration when speaking to clients whereas when they have more time and there are more clients seeking business, sex workers are believed to take fewer chances.

> *"Maybe they would go with that guy who they really knew had too much to drink...that in itself would lead them to believe that he was going to be difficult in some shape or form"* (Sexual Health Outreach Worker B).

> *"I think it does increase the risk, it disperses the girls to work other areas or my other concern is, it tends to... if she's only made forty quid and she's been stood there 8 or 10 hours and then somebody comes and ask for something that they wouldn't normally do but willing to give them fifty quid, they will jump into the car. They tend to let their barriers down a lot more and tend to put themselves in a lot more vulnerable position than if she had one hundred quid in her pocket. I think that does happen but we've got to police"* (Police Liaison Officer).

3. SEXUAL HEALTH

Sexual health needs of sex workers were constructed as different to non-sex workers' due to the number of sexual partners of a sex worker and the need of sex workers to work when they had a diagnosed STI. Nonetheless, service providers resisted the perceived negativity

within medical and moral discourses, challenging the discursive construct of pollution and the sex worker as a physical 'pollutant'.

Service providers believed sex workers understood sexual health within the notions of infection in an extremely narrow way, related to STI. Some service providers believed sex workers' perceptions of sexual health held historical, negative connotations associated with contagion, blame and guilt framed within the perceived negativity of medical and moral discourses related to the construction of pollution and stigma discussed in Chapter One. Despite attempts (e.g. one to one and group teaching sessions) to improve sex workers' perceptions of sexual health, service providers explained it was still constructed as an infection problem. Sexual health was described as a concern for sex workers when symptoms developed or when the sex worker felt unwell. Service providers claimed sex workers did not associate sexual health with well-being but within the discursive construct of pollution and stigma. According to Sexual Health Outreach Worker (A) sexual health for sex workers was not a positive experience, but was something that was dirty. Service providers reported sexual health was perceived by the sex worker as connected with unprotected sex with a client rather than something that could be openly discussed without shame. Sex workers believed they should have known better and been able to protect themselves. She went on to say *"...you need to get rid of all this secrecy and clandestine imagery about GU".*

Service providers identified varying health needs associated with sexual health; Chlamydia was the most common and an infection Sexual Health Outreach Workers and the GU Senior Health Adviser believed was increasing in incidence. Other service providers only equated STIs with HIV. The HIV Advice Worker and Police Liaison Officer claimed to know one sex worker who had been diagnosed as having HIV. Both Sexual Health Outreach Workers denied knowing any sex worker who was HIV positive. Only Sexual Health Outreach Worker (A) included a long-term consequence of untreated STIs, infertility.

> *"It's quite interesting how many women haven't got children...leads you to think well if you look at the age range of women that we see and they're not using any contraception in their own life you would hazard a guess that you would have high rates of infertility and this would come from untreated infection"* (Sexual Health Outreach Worker A).

> *"That's a real heavy emotional burden to have round your neck, the fact that you might have had an infection and spoilt your chances* [of having children]" (Sexual Health Outreach Worker A).

Service providers who were not directly involved with sexual health needs, such as the Police Liaison Officer and the HIV Advice Worker, believed sexual health was not constructed in a way that promoted openness, insight or understanding, therefore presenting a barrier to being 'safe' from infection. The HIV Advice Worker identified limited opportunity for an in-depth, *"honest"*, two-way conversation between Sexual Health Outreach Workers and sex workers when contact between them was on the street, handing out and receiving bags of assorted condoms. The HIV Advice Worker believed the underlying assumption was as the condoms were readily available they would be used. She believed in many instances that due to the circumstances of sex workers working from the street that this was untrue. Both the Police Liaison Officer and HIV Advice Worker believed sexual health among the sex workers was poor, although, obviously the Police Liaison Officer's main concern was 'soliciting as a crime', not health needs. STIs were identified as a health need. The majority of service providers' sexual health knowledge and construction of need and risk is based on experience of working with and observations made in respect to sex workers. This is not the case for the HIV Support Worker and Family Planning Nurse as unknown influences have affected the construction.

> *"No I would say that the knowledge about sexually transmitted infections in particular is really, really poor"* (HIV Support Worker).

> *"A lot of them have been walking around with various infections for years"* (HIV Support Worker).

> *"I would imagine that they would be at higher risk from sexually transmitted infections"* (Family Planning Nurse).

Service providers who worked within the discipline of sexual health were of the opinion that sex workers were aware of the risks attached to unprotected sex. The Sexual Health Outreach Worker (B) believed sex workers were aware if a condom was used then they were protected against *"...most things that they should worry about being passed to them"*. She claimed the depth of sexual health knowledge varied, but believed the basic knowledge among sex workers, in relation to condom use and blood borne diseases, was good. Sexual Health Outreach Worker (B) continued by identifying damaged mental health

as a major hurdle in the ability of some sex workers to retain information. Nonetheless, all service providers agreed that untreated STIs were a health need for a number of sex workers. Despite an increase in Chlamydia the GU Senior Health Adviser believed safer sex was the *"norm"*, or typical because,

> *"...there is generally an increase in things, we've had a lot more syphilis recently and lots of resistant gonorrhoea...but not among the working women"* (GU Senior Health Adviser).

Nevertheless, the GU Senior Health Adviser, continued by claiming whether a sex worker was seen as a *"professional"* or an *"enthusiastic amateur"* was a factor that maintained or posed a risk to their sexual health. The title of 'enthusiastic amateur' does little justice to the circumstances of sex workers. Many of the sex workers I interviewed were definitely not enthusiastic, just very desperate. Nonetheless, knowledge and experience were important factors when dealing with clients. 'Professional' sex workers were explained as those *"...who had worked for a while"*. The longer the length of time worked meant sex workers had more experience. They were described as not only having adequate knowledge of sexual health, but also possessing the ability to put that knowledge into practice. The GU Senior Health Adviser believed 'professional' sex workers did not use drugs, or if drugs were used, they did not affect the sex workers' ability to work safely and effectively. 'Enthusiastic amateurs' were described as those sex workers who worked irregularly. The GU Senior Health Adviser claimed 'enthusiastic amateurs' did not possess adequate or correct knowledge on how to protect themselves or due to acute financial need or drug use did not put the knowledge into practice, and therefore put their sexual health at risk. The narrative illustrates a clear divide between two types of sex worker, the 'enthusiastic amateur' is believed to be unable to keep herself 'safe', thus conforming with the medical discursive construct of safety and pollution, and the moral discursive construct of 'polluted' womanhood as discussed in Chapter One.

Due to the risk of HIV/AIDS, condoms have become a method of protection from infection and death, not just a method of contraception. A few service providers believed that due to the continual targeting of sex workers by the media, health authorities and specialised projects around condom use, the ability to monitor risk to sexual health was difficult due to an environment of shame. In this context education decreased opportunities for openness. The service providers believed sex workers want to conform to responsible behaviour (e.g.

not sharing needles, using condoms) but they do not want to admit to having unsafe sex as the following quotations show.

> *"They* [sex workers] *want to portray a good image...*[safer sex] *always, all the time with anybody. It's very difficult"* (Sexual Health Outreach Worker A).

> *"But that's why things aren't working. There should be an atmosphere or the climate where they can say "but I had difficulty using a condom that night because of this reason" not just dishing out condoms with the expectations that they will be used"* (HIV Advice Worker).

However, the environment of openness was not made easier by the interchangeable use of 'safe' and 'safer' by some of the service providers when discussing sex. For example, *"...around the two key agendas sexual health and safe sex and substance abuse..."* and then reverting to *"...obviously all the safety stuff around safer sex resources as well..."* (Sexual Health Outreach Worker B). The word 'safe' leaves no room for negotiation, sex is either 'safe' or unsafe, it is either/or with no middle ground, easily leading to blame and guilt if 'safe' sex is not practised. The use of 'safer' leaves more room for negotiation and represents many different levels of being 'safe', it allows sex workers to talk in a more open way. Interestingly, the Police Liaison Officer claimed sex workers openly admitted to having sex without using condoms, *"*[y]*ou tend to speak to lots of girls that do it without condoms. It's fifty quid instead of thirty".*

4. ILLEGAL DRUG USE

Service providers reported working within an environment of drug taking, within which sex workers' priority was having sufficient drugs to stop withdrawal symptoms and mask the feelings of self-loathing. In service providers' narratives, risk reduction, and thereby being 'safe', was not a primary concern for sex workers, thus by their behaviour sex workers confirmed the moral discursive construct of pollution, undertaking of irresponsible behaviour, and the medical discursive construct of reduced safety discussed in Chapter One. Service providers identified sex workers as different to non-sex workers who used drugs because sex workers worked in dangerous situations while under the influence of drugs. Non-sex workers were understood to use drugs while in a safer environment (e.g. their own home) where the dangers of rape, kidnap and violence were minimal, so not being fully aware of their surroundings was not as dangerous. Service providers claimed drugs provided the sex worker with protection from psychological breakdown. The ultimate

risk reduction aim identified by service providers was breaking the cycle between sex work and problematic drug use.

The analysis indicates that not all sex workers use drugs, some work solely to pay bills and/or provide a home for their children. Of the sex workers who used drugs not all used in a problematic way thus being able to control infection. However, drug use among sex workers was constructed by service providers to be normal, or typical, rather than an exception. The D&R Health Adviser when asked if sex workers were a large proportion of her patient group, replied, *'[y]es I have seen quite a number of drug users".* She automatically associated sex workers with drugs and as such conformed with dimensions of stigma and 'pollution', specifically control of infection. The Locum Drugs Worker believed that once a sex worker was categorised as a drug user, she was directed towards drugs services regardless of her individual circumstances. Problematic drug use was understood to be both physically (e.g. poor circulation, reduced mobility from nerve damage, poor appetite, constipation) and psychologically damaging (e.g. mood swings, psychosis). For instance service providers particularly the Sexual Health Outreach Workers and the GU Health Advisers discussed an increase in the number of reported cases of Hepatitis C. They were unsure whether the increase in Hepatitis C was a present growing problem, or whether people who had been infected for a while were now showing up due to the *"push"* by Health Authorities for high risk people to be tested.

Service providers identified heroin as the main drug of choice for sex workers. However, use of crack cocaine was seen to be increasing. Service providers believed that for 'other' service providers in 'Old Port' this use of crack cocaine added a further dimension to their construction of sex workers as a physical 'pollutant', continuing the moral 'pollutionary' discourse outlined in Chapter One. The Locum Drugs Worker reported drug dealers giving away crack with heroin, to get the drug user addicted. According to her, sex workers did not treat crack as a drug, which the service providers dealt with, the sex workers did not equate crack as a traditional risk to their health. On the return of sex workers' urine tests, which showed the presence of crack, the sex worker's response was, *'[o]h I never thought of that I've been using a few rocks as well".* There was apprehension among the service providers concerning increased crack use, as in the experience of other drug workers in other cities crack was perceived to change the character of the user. The assessment and treatment of health needs was explained as being negatively affected by an unpredictable and volatile personality. Nonetheless at the time of the interviews service providers identified health

needs, with relation to drugs, in terms of heroin and Valium. This may be due to crack being a relatively new drug in 'Old Port' and the way sex workers make sense of dependency, primarily linked to heroin. It became clear that risk reduction in this context was maintenance, and ultimately cure rather than prevention. To combat the physical damage caused by substance misuse, the primary need was identified as treatment to deal with physical and psychological dependency and misuse.

Service providers claimed sex workers took drugs to act as a block from sexual abuse and rape, to enable them to work and to mask damaged mental health, the same reasons given by the sex workers who were interviewed. Service providers understood taking drugs, including alcohol, to be a strategy to promote survival within a lifestyle characterised by diminished rights, social and gender vulnerability. Drugs were believed to help control the destructive feeling of self-loathing. As one service provider noted,

> *"...it's about the nature of drugs...b) they disinhibit c) they numb"* (Locum Drugs Worker).

In relation to damaged mental health, service providers identified illegal drug use as being a form of self-medication. It was stated by the Consultant Psychiatrist that if a personality is breaking down under stress, as in Post Traumatic Stress Disorder, medication, in the form of illegal drugs, is taken by sex workers to anaesthetise against the feelings of breakdown. Service providers believed sex workers hoped that drugs would block the nightmares, flashbacks, mood swings and depression, associated with damaged mental health.

Interestingly the Sexual Health Outreach Worker (B) talked about drug use as a way for the sex workers to boost their confidence while working. She believed that taking a small amount of drugs gave sex workers confidence to command control of the sexual exchange. Her viewpoint contradicts moral and medical discursive constructs of safety and in part 'pollution' examined in Chapter One, due to control of the sexual exchange increasing the control of infection. Nonetheless, they were keen to point out that there is a fine line to be drawn between control and vulnerability. It is very easy for the sex worker to overstep the line between control and loss of control. The Sexual Health Outreach Worker (B) claimed that if the sex workers were taking drugs, just enough drugs had to be taken in order to keep them relatively alert, and give them confidence in their ability to protect their health.

IV. CONCLUSION

This chapter illustrated service providers constructed health needs within a medical discourse, incorporating biomedical and social models of disease constrained within the remit and speciality of the service. Professional ideologies, an institution/power group influence, and personal bias were of particular importance as these lead to classification of sex workers as either the 'same as' or 'different from' non-sex workers, influencing their construction of need and risk. The service providers' experiences with sex workers, a social relational influence, directed their construction in relation to the 'state' of the sex worker, as desperate primarily caused by drug addiction and vulnerable, a victim of abuse and violence. These experiences influenced those with biomedical training to consider social aspects such as economic need, lifestyle, rights and power. The discursive construct of rights and power were discussed in terms of the sex worker as diminished and caused social care providers to construct the sex worker's need and risk as more severe than biomedical service providers. Service providers considered lack of power not just within sex work but also within the home life of the sex worker (e.g. children in care, poor partner relationships, lack of options) and not just occupational as understood by sex workers. For some service providers construction of need and risk was generalised from a small number of sex workers who they came into contact with.

The analysis of the service provider narrative indicates that all service providers identified damaged mental health, problematic drug use, violence and sexually transmitted infection as heavily interconnected needs and risks. Damaged mental health and problematic drug use were the most pressing health needs, whereas the highest risk to health was considered to be violence. However, the priority allocated to each was dependent on the remit and speciality of the project, training of the service provider, professional ideologies and personal bias. When constructed as a need damaged mental health was caused by drug abuse, sex work, sexual and physical abuse and previous mental health damage, when constructed as a risk the effects were the same as needs except for learning difficulties but including self-harm and suicidal tendencies. Bodily harm was constructed equally as a need and a risk, caused by violence and drug abuse. Sexual health damage was constructed as a need and a risk for STIs caused by unprotected sex, but infertility was also identified as a risk for untreated STIs, with pregnancy as a risk from unprotected sex.

The discursive construct of pollution continues within medical discourse as illustrated in the perception of the sex worker as 'doubly polluted' (e.g. STIs and problematic drug use) but

the source expressing this construct is identified as 'other' service providers. Also attributed to 'other' service providers is the perception of sex work and drug use as being morally reprehensible infecting 'normal' values. Moral pollution constructs were visible in negative attitudes (e.g. differentiation between 'normal' and 'abnormal'). Stigma was raised within stereotypes, that of the sex workers as drug user. Problematic drug use and work location were perceived as decreasing safety and increasing risk. The stereotype of the sex worker as 'pollutant' was replaced by the promiscuous non-sex worker, in the perception of the GU Senior Health Adviser. The professional sex worker as safer was explained in terms of the 'professional' sex worker knowing the responsible way to work as opposed to the 'amateur'.

Chapter Six analyses the sex worker narrative relating to access and provision of health care, identifying the system of rules that direct their construction. The findings are explained within the discursive constructs of pollution, stigma and safety.

Chapter 6

ACCESS AND PROVISION: POLLUTION, STIGMA AND SAFETY

Chapter Four in fulfilling the first objective identified sex workers' perception of need and risk explained within a construction directed by underlying influences. This chapter builds on that knowledge to meet the third objective, to identify the provision sex workers sought, their construction of access and the underlying influences.

The discursive constructs of safety, stigma and pollution connected with drug use, mental health and sexual health underpin their choice of provider and type of health care sought. In addition the analysis demonstrates that when to use and how to access health care services was shaped by broader social processes and structures (e.g. economic necessity, family structure and dynamics). The sex workers described feeling stigmatised due to the perceived beliefs of 'important others' (i.e. service providers) regarding irresponsibility and differentiation of sex workers. For instance irresponsible due to the belief of service providers that some sex workers practiced unsafe sex with multiple partners and used drugs problematically thus were different from non-sex workers. In this context the discursive constructs of pollution and stigma are used to explain how sex workers believed they were acted upon by service providers due to the belief of others that they are 'polluted' and the choices sex workers make (e.g. condom use, type of client) due to their belief that those around them, specifically clients, can 'pollute' them. Sex workers perceived 'pollution' in turn was associated by 'others' with physical and moral contamination caused by STIs, selling sex and the use of drugs. Even if sex workers did not use drugs, they believed drugs and prostitution were linked by important others framed within medical, moral and legal discourses.

Understanding of and action regarding need and risk were constituted and refracted by the social contexts of the sex work, drug usage and discursive framework. The ways in which STIs, mental health and drug usage were made sense of and intertwined with safety, stigma and 'pollution' affected the knowledge of the sex workers in relation to health care services, the use they made of this knowledge and which health care services were available to them. This chapter will explore these issues illustrating conformity with and resistance to discourses and discursive constructs identified in Chapter One. The next

sections of the chapter illustrate that use of health care services was not solely dependent on safety, stigma or 'pollution', sex workers had to be aware that health care services were accessible to them. It must be borne in mind that the gatekeepers were Sexual Health Outreach Workers and the sex workers interviewed used this service provider to varying degrees. To be true to the data it must be accepted that there is a bias in favour of the Sexual Health Outreach Project throughout this chapter.

I. KNOWLEDGE OF HEALTH CARE SERVICES

This section of the chapter will show that incidence of STIs, form and severity of violence, severity of mental health needs and drug addiction impacted on the sex workers' knowledge of health care services. Knowledge of services varied greatly between the sex workers. Certain service provider services were reportedly accessed more often than other services and these can be classified as the primary health care services and providers. Sexual Health Outreach was the primary contact accessed for preventative care and lifestyle maintenance. Sexual Health Outreach Workers provided psychological and practical support and equipment to keep the sex workers safer. The GU Clinic was accessed to obtain both preventative care (e.g. vaccinations, blood tests, internal examinations) and corrective treatment (e.g. antibiotics for STIs). Drug agencies were used for prescriptions for substitute medication, stabilisation and detoxification. GPs were accessed for substitute medication, smears, contraception and medication for thrush, cystitis and damaged mental health. All of the sex workers interviewed were registered with GP surgeries.

For health needs that involved sexual health and drug use, sex workers were aware of the main health agencies dealing with these problems. Their narratives illustrate in part conformity with the medical discursive constructs of safety and pollution. They wanted to be kept 'safe' from infection and they had an awareness of the health agencies that could facilitate this. Katrina as a non-injecting drug-user made sense of health care provision within sexual health, as a preventative service and not in terms of a service providing corrective treatment. She claimed she had no need of treatment, as she was and had always been 'clean'. 'Clean' was a word used by many sex workers to describe an absence of infection or not using injectable, habit-forming drugs. This clearly illustrates resistance to the perceived negativity within medical and moral discursive constructs of pollution discussed in Chapter One, specifically the sex worker as dirty and a physical 'pollutant'. When Katrina was asked if she used any other health care provision, apart from the sexual

health outreach and the GU, her reply was no, she had no need to use anything else. She believed these two services provided all the information and supplies that were necessary to keep her 'safe' from infection. Cleanliness framed within the discursive constructs of pollution, safety and stigma underpinned Katrina's construction and use of health care provision. However, for Belinda who described a heavy use of heroin and speed in the past, but was now on a maintenance prescription of 20 millilitres of methadone, Temazepam and a reduced amount of speed, health services were very much linked to her drug use. Avoiding withdrawal underpinned Belinda's construction and use of health care provision; safety as discussed in Chapter One was not a primary consideration within her narrative. She was, and had been for approximately ten years involved with the two largest drug agencies in 'Old Port'. Health services, outside her drug use, including those dealing with sexual health, were explained as unimportant to her. Drugs were identified as the most important issue in her life and an area with which she felt she needed the most support.

Understandably, the less sex workers needed the services, the less knowledge they had concerning the availability of services. As indicated in Chapter Four a temporal distinction existed between need and risk, thus sex workers only knew of service providers in respect of their current need and future risks. Sex workers discussed becoming aware of health care services either through word of mouth (e.g. other sex workers, friends, family) or through other agencies that they used. The sex workers working from the streets asserted they had the added advantage of being well informed of health care services due to the existence of a sexual health outreach team, specifically for sex workers working from the street. It was apparent that translating knowledge about health care services into use of health care services, was dependent on the extent of both mental health needs and drug use.

Ebony and Nikki both appeared very knowledgeable about the health care that was available. Both described a large but varied drug use, had accessed and maintained close ties with the sexual health outreach workers. Both, since the ages of four and five respectively, reported a history of mental health problems including psychotic behaviour, self-harm and depression. They explained asking for help when they felt life was getting out of control. For instance Ebony listed nine different health care services she had used, six of which were drug related,

> *"GU,* [name of centre] *which is the voluntary drug agency, sexual health outreach, statutory drugs centre, Young People's Centre, general advice for anything affecting young people, Community Drugs Service, Community Alcohol Service, Social Services Substance Misuse,* [name of hospital ward] *which has four specialised beds for drug rehab and detox"* (Ebony).

Lou had been working from the streets for nineteen years. At the beginning of her *"career"* she explained being addicted to heroin but had been *"clean"* for fifteen years. Due in part to a mobile outreach ambulance run by the GU clinic and a drugs project, which was running prior to the present sexual health outreach project, Lou believed she was knowledgeable about the availability of various health care services. She knew of the sexual health outreach workers, GU, and the two main drug agencies. For Lou, sex workers working from the streets had no excuse not to be aware of the different health services available, due to the presence and work of the sexual health outreach project, and only had themselves to blame if they were unaware. Her narrative confirms promotion of personal responsibility and awareness of risk as discussed in Chapter. She continued by saying,

> *"*[t]*he* [sexual health project] *is out there, the* [sexual health project] *is out there at least twice a week and their door is always open, they* [also] *have telephone numbers"* (Lou).

The analysis illustrates that lack of work experience did not automatically result in a lack of knowledge of health care provision. Kitty had very little experience of sex work as, at the time of the interview, she had only been working for three months. That said she had the advantage of working in a parlour, which permitted visits from the sexual health outreach worker. At the time of the interview Kitty reported already making use of the GU clinic for her Hepatitis injections, a situation explained to have arisen from the efforts of the sexual health outreach worker and not the managers of the parlour. Although she admitted to not being *"...keyed up on all the help that is available"* she claimed to use the sexual health outreach worker to point her in the right direction for health care. Kitty's contact with the sexual health outreach worker illustrates that despite the claims by street sex workers that they were more informed because of their contact with sexual health outreach, sex workers working privately also benefited from this service.

Sex workers' knowledge of health care services did not automatically result in them using the health care service. The following section will explain the reasoning behind sex workers'

choice of health care services in terms of the discursive constructs of safety, stigma and pollution.

II. CHOICE AND HEALTH CARE SERVICES

This section of the chapter will illustrate that sex workers' choice of which health care services to use, and whether or not to use a health care service was not made in isolation. Choice of service was dependent on the sex workers' ability and wish to not only keep themselves 'safe' when working and understand information given to them but also to feel 'safe' when using a health care service. Choice was also influenced by the extent and effect of stigma intertwined with both safety and 'pollution' constructed within medical, moral and legal discourses.

Health needs and health risks caused by sex work, underpinned by stigma and 'pollution', particularly those health needs caused by sexual intercourse, led sex workers to use the sexual health outreach and GU clinic. Sex workers believed they were contaminated by the actions of the client again their narrative illustrates resistance against the moral discursive construct of the sex worker as physically 'polluting' but identifies the client as the physical 'pollutant'. On the other hand health needs whilst following responsible behaviour were problems that sex workers assumed to be caused by non-work related activities therefore not worthy of blame or guilt. They perceived any woman, regardless of whether she sold sex, could have the same health needs. The health need was not made sense of within the stigma or the perceived immorality of selling sex and if it was due to selling sex the health need was trivial (e.g. thrush caused by responsible behaviour using condoms) with no 'pollutionary' overtones. These minor health needs were explained as often dealt with via their GPs who provided health care for non-work related health needs such as oral contraception and medication for mental health needs (e.g. depression). The sex workers were clearly grouped into those who used the services in a preventative way (e.g. GU for regular sexual health checks, Hepatitis C injections), and others who used the services in a corrective way if they had a health need (e.g. GU for symptoms of or contact with a STI). Some sex workers, even when their health had been put at risk at work (e.g. rape, split condom) reported avoiding the traditional health services (e.g. GU clinic).

The GU clinic was perceived as posing no risk to sex workers of 'important others' (e.g. family, friends) finding out what they did for a living. The clinic had the added advantage of

the sex workers being able to give a false name and address but a real date of birth without questions being asked and no one questioning the information given. All of the sex workers interviewed except one realised the GU clinic was a completely separate health care provision and would not inform their GP. Two of the sex workers talked about using the GU clinic with their partners using their real identities, but when attending the clinic for work related health needs these sex workers explained using their work identities. Even though the sex workers acknowledged the staff made the connection between their real names and pseudonyms, if a work related infection was detected they believed it remained completely separate from their private lives. Notions of 'pollution' remained only in their working lives and even then sex workers' narratives challenged the perceived negativity of moral discursive construct discussed in Chapter One. They were not the 'pollutant'.

Although sex workers described primarily using health care services to enable them to work they also wanted to keep themselves 'safe' from sexual or blood-borne infection. However, choice of health care, if health care was actually used, was understood as not only dependent on the health need, or to protect themselves against health risks, but what their perception of the service provider's attitude and behaviour would be when the service provider knew they sold sex. Resistance to stigma and notions of 'pollution' and their perception of keeping 'safe' intertwined, with the presumed immorality attached to both their activities within sex work, and their drug use, governed the choices sex workers made. These discursive constructs are explored in the following sections.

1. KEEPING 'SAFE'

Sex workers used the word 'safe' and not safer as to go out on the streets they had to believe they would be completely 'safe' from behaviour and actions that could seriously harm their health. Any acknowledgement made to the fact that dangerous situations could happen to them they explained would negatively impact on their mental strength effecting their ability to work. Sex workers constructed safety not only in terms of 'safe from others' who could 'pollute them' and being 'safe' from the effects of withdrawal but also and of interest to this study, the requirement to feel 'safe' within their contact with the service provider. Safety was linked to a trusting relationship within which they were secure from negative attitudes, their identity remained confidential and where they could be honest about prostitution and drug use. The sex workers felt 'safe' when they were not being negatively criticised for selling sex and were treated the same as non-sex workers. It was clear the need to feel 'safe' and secure was extremely important to the sex workers. They

explained maintaining contact with specific service providers was due to the service providers' attitude towards them. In particular the sex workers felt that the sexual health outreach workers when giving the sex workers support, guidance and advice did not judge, were not condescending but were open and friendly. The sex workers discussed that when coming into contact with the sexual health outreach workers they did not feel as though they were acted upon as 'polluted' or stigmatised. The sex workers' perception was that they were not the 'pollutant'. When coming into contact with the Sexual Health Outreach Project sex workers felt they had the power to make choices, increasing their rights, challenging the discursive constructs of diminished rights and power examined in Chapter One. It most be remembered sexual health outreach is solely for sex workers and as such should not hold stigmatising attitudes. Generally sex workers do not want to be differentiated from non-sex workers but in using this service they are differentiated; interestingly in this context they perceive no stigma.

For sex workers the knowledge that confidentiality would be maintained built a relationship that enabled them to talk about any health needs or health risks no matter how personal. Abby and Lou echoed the feelings of many of the sex workers interviewed,

> *"[a]ll the people that I have contact with I feel safe to talk about anything to them"* (Abby),

> *"...trust is very, very important, a working girl has got to be able to trust her counsellors they have to know confidentiality* [is maintained]*, they also have to know that they care..."* (Lou),

> *"*[Outreach worker] *is my friend and a person's advice that I value because* [outreach worker] *has forgotten more about working girls than I will probably ever know she is just a regular mine of information"* (Lou).

For Abby who reported growing up in over thirty children's homes, foster care and secure units confirming social and gender vulnerability discussed in Chapter One, the ability to feel 'safe' in her contact with health service providers was paramount. She was 13 during one of her stays in a secure unit and at this point she described the use of pin down techniques by the staff to control her. As the following quotation illustrates being pinned down added to the distrust she already felt towards people who were supposed to be keeping her 'safe',

"I've grown up knowing and thinking that I couldn't trust the professionals around me because they just use and abuse me" (Abby).

To keep 'safe' while working relies on making and maintaining contact with a service provider, using the supplies made available to them to reduce risks to health and the type of barriers preventing or limiting access. These issues are examined in detail in the following sections.

(i) Contact

For many sex workers the sexual health outreach workers were identified as their first contact with health care provision. Sexual health outreach workers made contact primarily on the streets but this method of contact was reliant on the sex workers working on the night and between the times the sexual health outreach workers were operating in the red light district. Maisie described first meeting the sexual health outreach workers giving out condoms three years previously when they had approached her when she first began working on the street. However, Diane recalled that she had been working for about six months buying her own condoms before she came into contact with them. Since this first contact Diane recounted a lengthy relationship with sexual health outreach.

It was evident that contact with the sexual health outreach was not dependent on the length of time that sex workers had been working. For instance Summer explained that she had been working for seven years in private premises among which were parlours and a licensed massage parlour. However, she had only been using the sexual health outreach workers for five months before the interview because she had started working in a parlour that allowed the sexual health outreach to visit. Fiona who had been working from private premises for ten years had only in the last eighteen months to two years used the health provision, and advice given by the sexual health outreach team told a similar story to Summer. Contact was reportedly made due to the sexual health outreach worker cold calling on the premises and being allowed entry. So for many of the parlour sex workers sexual health outreach was not their initial service provider but had become their primary source to keep themselves 'safe'.

Liz stated her first point of contact, in common with many of the other sex workers, would be the sexual health outreach worker if she needed supplies to keep herself 'safe', had a concern in relation to her health or any other daily problems,

> *"I would speak to her* [sexual health outreach worker] *first as I've built up quite a close relationship with her I can talk to her about almost anything"* (Liz).

Contact by the sexual health outreach workers appeared to be maintained even when the sex workers moved place of employment. For sex workers, contact was not only maintained due to the non-stigmatising behaviour of outreach staff but due to the perceived attitude of projects or agencies administration staff. Sex workers narratives illustrated that they felt neither physically nor morally 'polluted'. First point of contact was recounted as being important. Dee felt very comfortable going to the building despite it being primarily known as a building for drug-related agencies and felt no different from non-sex workers. Dee found the reception staff very welcoming both in person and on the phone.

> *"You go to the* [sexual health outreach project] *and the receptionist there is always very pleasant, very friendly and will always try and get through to either* [of the sexual health outreach workers] *and if she can't she will always tell me that she can't, she will give me a time to try again, very, very helpful and then to actually go up* [to the building] *is always brilliant"* (Dee).

(ii) Accessing Supplies

In an attempt to keep themselves 'safe', the sex workers make use of varying health care supplies from service providers. Information and advice (e.g. violence, contraception methods), daily supplies, supplies attached to an appointment, and advocacy and support will now be discussed.

(a) Information And Advice

The majority of sex workers indicated the primary source for information and advice was the Sexual Health Outreach Project. As stated previously this was because of the relationship that existed between them, enabling the sex worker to feel 'safe' and secure during contact, and the service providers' reputation of knowledge. It was due to advocacy support from the Sexual Health Outreach Project that sex workers reported accessing other service providers. However from analysis of the interviews it was apparent that the level and depth of advice given by the sexual health outreach worker to keep the sex workers 'safe' varied. For instance Lou was an articulate, non-drug using *'career'* sex worker who had been advised by the sexual health outreach worker to use her diaphragm while working. None of the other sex workers interviewed mentioned using a diaphragm to protect against work related health problems. Lou explained she had primarily used the diaphragm as an additional contraceptive to protect against unwanted pregnancy. In using

the diaphragm while working the sexual health outreach worker had explained to Lou that she was protecting her cervix against cancer,

> *"I hadn't thought of that possibility that it* [the diaphragm] *was actually protecting the cervix...as I don't know if I will have any health problems later on in life from the number* [of clients]*"* (Lou).

Lou's narrative illustrates some sex workers had an increased awareness of risk and the need to be 'safe', controlling against infection in turn resisting the moral discursive construct of the sex worker as a 'pollutant' as discussed in Chapter One. Interestingly not all sex workers had received the same level or depth of information or advice. For instance Katrina who was also a non-drug user, managing a parlour, made no mention of the possibilities of using a diaphragm but instead described an unscientific protection method, how she used two balls of cotton wool to protect herself against the effects of a split condom,

> *"...the cotton wool will get most of it so I just pull it out, clean myself out...I just stick my fingers up with a wet wipe give it a good scrape around and bring it all down"* (Katrina).

Another source of information sex workers working on the street described using to keep themselves 'safe' was the sexual health outreach projects 'ugly mugs' list. After Maisie had been violently attacked she recounted speaking to the sexual health outreach worker who put the description of both the assailant and the attack on the ugly mugs list. The assailant had never been caught but Maisie felt the list was a good idea because other sex workers had been warned about the assailant. As Maisie went onto explain another attack was linked with the same man,

> *"*[t]*here was another incident well it was the same sort of attack, a friend of mine, well we think it was the same guy due to the way he was, his car and the way it smelt"* (Maisie).

Lou claimed that before the sexual health outreach initiative to compile descriptions of known violent sex attackers, the sex workers did not have a network of information. The limited information that was available came from the police. As Lou further explained,

'[y]ears ago if there was a baddie on the patch it wasn't unknown for the vice squad to spin around and tell you..." (Lou).

However, 'Old Port' no longer had a vice squad and sex workers indicated the relationship with the police was unpredictable. The information contained within the 'Ugly Mugs List' would not be available from a biomedical service provider, due to the limited level of interaction and feedback from sex workers. Sex workers' perception of the Sexual Health Outreach Project as proactive in a trusting relationship creates for the sex worker an understanding of someone who cares and does not judge. This had engendered a 'working together' relationship within which stigma was reduced and safety was perceived to increase, resisting the moral discursive constructs discussed in Chapter One.

There was no similar list for the parlours and although Katrina claimed that having *'bad'* clients was very rare she went on to say that she had banned approximately forty clients from using the parlour due to obnoxious behaviour. Katrina defined obnoxious behaviour as behaviour that did not respect her as an important individual and involved trying to kiss her, trying to have sexual intercourse without a condom and being generally disrespectful in the way the client talked to her or the other sex workers who were working. The narrative illustrates the legal discursive constructions of rights (i.e. the right to 'choose') and power (i.e. the ability to exercise that 'choice') as understood by a sex worker. She believed this 'choice' decreased her vulnerability and limited damage within her lifestyle. This extends the viewpoint of power relationships discussed in Chapter One as in this instance Katrina's narrative resisted social and gender vulnerability.

(b) Daily Supplies

The supplies sex workers mentioned that kept them 'safe' in their work were sexual exchange (e.g. condoms, lubricants) and drug use items (e.g. clean needles, Sharps bins). It was very evident sex workers relied heavily on the sexual outreach workers to provide supplies and information to keep them 'safe' from work related health needs and health risks. Eight of the sex workers interviewed recounted close relationships with the sexual health outreach workers due to needing support whilst using their drug of choice. These sex workers constructed support in the form of clean needles, sharps bins for the 'safe' disposal of needles and psychological support. Belinda claimed to have relied heavily on the sexual health outreach worker for psychological support when she had been stressed which in turn had increased her drug use,

> *"I was really stressed out and getting really angry and all that and she came* [sexual health outreach worker], *I was getting to the stage were I just wanted to kill everybody that were winding me up and I had sort of lost the plot a bit"* (Belinda).

In obtaining supplies to keep themselves 'safe', some of the sex workers relied solely on contacting the Sexual Health Outreach Worker by phone, others recalled meeting the Sexual Health Outreach Worker on the street and some sex workers visited the project. Delivery to the sex workers either at home or their place of work was identified as by far the most common way of getting the supplies. Delivery from the Sexual Health Outreach Project to the home of the sex workers greatly increased access to the project for the sex workers. While she was working Belinda had home deliveries, as did Queenie,

> *"I used to get a delivery of loads, once, twice a week I used to get delivery of clean needles and sharps bins"* (Belinda),

> '[Sexual health outreach worker] *always delivers my works and she always takes away my dirty pins"* (Queenie).

Polly described her first contact with the sexual health outreach while she had been working in one of the parlours that allowed outreach to visit. Since setting up on her own Polly claimed to have contacted the outreach worker on several occasions. The sexual health outreach worker always visited Polly at home, bringing supplies to keep her 'safe' at work and relevant advice. As such Polly saw no need to visit the project as supplies were delivered to her door.

> *"If I need to speak to her then she comes to see me...I'm quite happy ringing her up and seeing her here"* (Polly).

Another important factor reported to contribute to keep the health of the sex workers 'safe' and affect their choice of service provider was that condoms and lubricants were free. Before the advent of sexual health outreach Lou recalled buying her condoms from Boots in packs of twelve. Free condoms for Belinda were identified as a major incentive to keep herself 'safe' while working,

> '[y]*ou gets as many condoms, you name it you've got every single condom going, do you know what I mean, it's really expensive in the chemist but it's not like you have to pay for them* [from sexual health outreach]" (Belinda).

The sex workers' narratives indicate the important role Sexual Health Outreach play in promoting personal responsibility of the sex worker and safer sex discussed in Chapter One. However, according to other sex workers the sexual health outreach had recently changed the types of condoms they stocked. Maisie in the past reported using the extra strong condoms but she claimed due to funding cuts the Sexual Health Outreach Project had stopped supplying them to the sex workers. Even though she claimed to be unhappy with the new ones provided as they were not brand names and felt *"thin"* she was not prepared to buy her own due to the cost, *"it's like £5 for a pack of three"*, indicating there were certain conditions attached to keeping 'safe'. Interestingly there were other service providers from whom sex workers could receive free condoms but they were not understood as an alternative supplier. For the sex workers who had worked in different countries and towns a service that delivered and the ease of the delivery of the condoms was explained to make a huge difference. Katrina described working all over the country but 'Old Port' was the only city that she was aware of that had a sexual health outreach team. Prior to working in 'Old Port', to keep herself 'safe' she bought her own supplies of condoms,

> *"*[c]*ondoms are bloody expensive and I've worked in places where I've been doing 70 or 80 men a week sometimes and that is a hell of a lot of money, a hell of a lot of money a condom, they are nearly a pound a condom"* (Katrina).

However, some of the provisions that the sexual health outreach team provided to keep the sex workers 'safe' were perceived to be too impractical for the sex workers to use due to the negative reactions of the clients, for instance,

> *"*[s]*he's bought us some rubber latex pieces to go there* [pointing to her pubic area], *it's good in theory but in practice you wouldn't get a client to lick that, a rubber sheet that you put over your private bit for them to lick as opposed to licking you"* (Katrina).

The analysis indicates the sex workers' choice of service provider to keep themselves 'safe' is based on ease of use, which also allows them to continue working.

(c) Supplies Attached To An Appointment

Supplies to protect sex workers against infection were not only understood to be the traditional supplies of condoms, clean needles and Sharp Bins but also included Hepatitis C vaccinations. Some sex workers identified Hepatitis C to be a risk to their health,

extending medical discourse discussed in Chapter One. Hepatitis was a new issue within the discursive constructs of safety, stigma and pollution. Drug using sex workers made sense of the risk in relation to the use of unclean needles whereas non-drug using sex workers constructed it as a risk during sexual contact through exposure to sweat. The risk Hepatitis C caused to their health was seen to diminish after having the vaccinations. However although the vaccinations were freely available sex workers explained having to make and attend three consecutive appointments. Sex workers acknowledged that attending the GU clinic for the course of three injections was usually arranged by the sexual health outreach workers. The sexual health outreach worker informed Cath about the vaccination but as she went onto explain another sex worker whom she worked with in the parlour confirmed the importance of the vaccinations,

> *"I think it was through* [sexual health outreach worker] *some of the girls know about it already, one of the girls here had had it done down where she lives and she said get it done because it's good but it was through* [sexual health outreach worker]" (Cath).

A few of the sex workers recalled knowing about the Hepatitis injections through working *"in nursing"* (e.g. residential homes). Katrina and Abby reported having had the first or the second injection while working in care homes but had not finished the course due to leaving the jobs,

> *"I did nursing so I know all about it. I've already had the course but I forgot to take the third one because it was such a big gap"* (Katrina).

> *"I only had it because I had to as part of working there* [residential home] *if I hadn't been working there I wouldn't have had it"* (Abby).

Summer was only just having the course of injections despite the fact that she had been working for seven years. Before she had contact with the sexual health outreach workers she admitted she had not known Hepatitis represented such a risk to her health and had not been vaccinated "...*cause I didn't know it was available before".* Summer clarified she knew of the existence of the vaccination but not that it was important for sex workers to have it or that it was *"so easy"* for sex workers to obtain it, as she herself explains,

> *"I did know that health workers had to have it...but I didn't know it was available to working girls on the scale that it is. I didn't know that all you had to do was ask for it"* (Summer).

Only Lou knew the vaccinations were available to sex workers before the start of the sexual health outreach project in 1996. She explained being given the vaccination by the GU outreach service that had preceded the sexual health outreach project. The GU outreach were identified as keeping sex workers informed on all aspects of sexual health and in Lou's opinion had not just concentrated on HIV and AIDS in an era when the virus was leading to *"moral panic and scape goating"*. She continues,

> *"[f]or the first time we were made aware of other things apart from HIV, we were made aware of Hepatitis B and of course now there is Hepatitis C...but ask me six to seven years ago if I had ever heard of Hepatitis and I hadn't. I may have heard of HIV but I hadn't heard of Hepatitis or how easy it is to catch".* (Lou)

Despite the involvement of the sexual health outreach workers for the last five years on the street and approximately two years in some of the parlours, many of the sex workers reported only just having the course of injections and a few claimed they did not know that it was available. Abby recounted a long history of involvement with drug agencies and sexual health outreach. She claimed to know of the existence of Hepatitis but had never recognised it as a disease that could be a risk to her health or *"[t]o be honest I wasn't aware that it* [the vaccine] *was available to sex workers"*.

Polly was not aware of either Hepatitis or that there was a vaccination that she could be given. She was unsure whether she had already been vaccinated against Hepatitis C. On asking her husband she was told by him that the last injection she had been given was the booster for Tetanus not Hepatitis. On learning this she replied *"[a]nd what about this Hepatitis thing should I have one of these as well"*.

However Kitty who had only been working for three months in one of the parlours and had contact with the sexual health outreach workers explained,

> *"I've already had two of the injections to counteract that* [coming into contact with sweat while doing domination] *and I've got the third one in December"* (Kitty).

Appointments related to other needs and with other service providers were not identified by the sex workers. In the specific example raised of Hepatitis, the sex workers constructed it as a risk that may not ever arise, as such there was no safety concern, it was not a need as it did not stop them working. The narratives illustrate that Hepatitis did not have the same

stigmatising or 'pollutionary' aspects as other blood-borne infections discussed in Chapter One. Appointments were not flexible enough for their chaotic lifestyle, and took them away from work. A few sex workers knew of Hepatitis and had the vaccinations only because of the requirements of previous employment, or the persistence and support of sexual health outreach workers.

(d) The Sexual Health Outreach Project – Advocacy And Support

Sex workers realised their chaotic lifestyle reduced their safety increasing the need for support and guidance. Their narratives illustrated sex workers wanted to control infection and remain 'safe' resisting the perceived negativity within moral and medical discursive constructs. They realised diminished rights and the dynamics of power relations discussed in Chapter One at times made this difficult, but with support from SHOP they had the opportunity to increase both their right to health care and power to facilitate that right, challenging the discursive construct of vulnerability. The Sexual Health Outreach Project had been specifically designed to address the limitations in biomedical health care provision. As such choice of service provider is limited but choice of when to make contact and access the Sexual Health Outreach Project is not.

In using a service to keep themselves 'safe' sex workers reported a great deal of help from sexual health outreach and not only in connection with sexual health and drug addition. The help gained made the sexual health outreach workers the first point of contact for many of the sex workers.

> *"It would probably be* [Sexual Health Outreach Worker] *I would speak to first as I've built up quite a close relationship…I can talk to her about almost anything"* (Liz).

> *"It would be* [Sexual Health Outreach Worker] *it wouldn't be my nurse or my doctor...*[Sexual Health Outreach Workers] *understand I can tell them everything and doctors don't sometimes understand everything right away he's a good doctor but he doesn't understand how I live and that, he wouldn't understand the emotional problems"* (Babs).

Use of the service was linked to psychological support, for help dealing with everyday problems in relation to circumstances that led them to work (e.g. poor financial situation) and once working dealing with situations and stigma that could arise if other service providers found out they sold sex. Everyday problems as explained by sex workers were

primarily help obtaining housing and claiming benefits. By securing stable accommodation and ensuring the correct benefits were paid at the correct level this help indirectly increased the sex workers' safety. For instance Babs at the time of the interview described living in bed and breakfast accommodation. She explained the sexual health outreach worker had found this accommodation after she had contacted the project unable to cope with the *"drug scene"*, in particular, *"...the stealing, the bitchiness, the heavy drug use"*. Babs believed the bed and breakfast offered her 'safe' but temporary accommodation away from an environment that put at risk her psychological and physical health. With a large amount of help from the sexual health outreach worker Babs was obtaining letters from biomedical service providers to support her application for a *"council flat"*. The sexual health outreach worker was also mentioned as being instrumental in making sure Nikki had letters from her psychiatrist explaining her psychological health needs. She then took Nikki to the local Social Security offices to help her claim Incapacity Benefit and Income Support using the letters as supporting evidence.

It became evident that additional incentives for sex workers to use other health services included the sexual health outreach workers arranging appointments and taking the sex workers to those appointments. It was acknowledged that the sexual health outreach workers initiated access to other service providers and then acted as 'advocates' for the sex workers within these services. The sex workers hoped that if a sexual health outreach worker was with them then stigma of sex work would be reduced. At the most basic level accompanying the sex workers to appointments provided sex workers with support and the courage to actually go. The sex workers discussed not having to complete forms or questions by themselves and they also had someone else there if they were unsure about what was said or if the examinations indicated that there was some form of infection.

Sex workers recalled sexual health outreach workers accompanying them to appointments that the sex workers felt they could not take family or friends with them for support. Some of the sex workers believed the sexual health outreach workers reduced the feeling of isolation. Isolation was identified as being caused by a lack of understanding of the sex work situation and lifestyle, of the fears attached to working on the street and the stereotypical constructs contained within moral, medical and legal discourse as discussed in Chapter One. Sex workers' narratives indicated that family and friends would perceive them as morally and physically 'polluted', undertaking illegal activities. Although they had illustrated resistance to this perception when describing 'prostitution as work' and

'prostitution as control' explained in Chapter Four, resistance to the negativity contained in discursive constructs was extremely difficult when they were socially and gender vulnerable and wanted to keep work and non-work lives separate due to stigma. For instance Lou found the sexual health outreach worker provided the outlet to her feelings and fears that important others in her life were unable to provide. This she believed helped to keep her psychological health 'safe' and maintain her sanity,

> *"I'm living the working woman's scenario...it can be quite a lonely existence because you don't have anyone to talk to, you can't discuss it with your partner. If you discuss it with your friends then they think it is something of a giggle and sometimes you want to laugh about it, cry about it, scream...you have to rant and rave to somebody"* (Lou).

To help keep the sex workers 'safe', sex workers talked about how sexual health outreach workers informed them of sympathetic GPs. Sympathetic was understood in terms of being non-judgemental, someone they would be able to easily talk to. Dee reported recently changing her GP on the guidance of the sexual health outreach worker. Queenie acknowledged she had been confused between Hepatitis B and Hepatitis C so the sexual health outreach worker recommended and then arranged for her to go and have a talk with a worker from an advice centre dealing with blood-borne viruses. It was clear Polly along with many of the other sex workers 'trusted' the Sexual Health Outreach Workers to advise them on which health care services they needed to use. This type of 'trust' gave the sexual health outreach worker power as illustrated by Polly,

> *"I would get advice from* [sexual health outreach worker] *and what ever she thought I would do"* (Polly).

Once the sex workers used the sexual health outreach workers they could be informed of or could be referred to other health service providers. Abby's Community Psychiatric Nurse had referred her to the sexual health outreach project when she had returned to the streets to work due to increased drug use. Abby recalled she had been to the building where the outreach project was based a few years previously for clean needles but this had only been a one off. Belinda recounted being introduced to a sexual health outreach worker via her drugs counsellor,

> *"...she* [drugs worker] *was working with* ...[sexual health outreach worker] *and she popped around to see me and* ...[sexual health outreach worker] *came with her"* (Belinda).

(iii) Barriers To Safety

The following section will illustrate that barriers to safety were constructed as traditional forms of access combined with the actions and perceived negative reactions of important others, in addition limiting choice and reducing safety. Traditional access represents waiting lists and appointment systems. Important others as identified by the sex workers include partners, husbands and massage parlour managers.

(a) Traditional Forms of Access

The forms of access refer to the access protocols mainly within statutory biomedical service providers identified by sex workers. These access protocols were designed to allow a large population to access a small number of specialists for care, but waiting lists and appointment systems were understood to limit access, which for a chaotic population such as sex workers was a major barrier.

Four of the sex workers who were using drugs and wanted to seek help for their drug use, identified waiting lists as a major barrier to keeping themselves 'safe'. Even if the sex workers were prepared or able to wait they described a *"huge"* waiting list, reported to be well over a year. Being unable to circumvent the lengthy waiting lists for the drugs services was the reason given by some of the sex workers when discussing their choice and reason for registering with a particular GP. Ebony explained recently changing her surgery to one with a GP who would prescribe substitute medication. Ebony's psychiatrist was based at the Statutory Drug Project and even though the staff knew her, she complained the waiting lists were still a barrier. Ebony claimed her new GP had agreed to prescribe substitute medication for her if Ebony's psychiatrist gave permission.

Tracey reported that when she needed a prescription she had problems accessing one of the drug projects due to the appointments system,

> *"I think it was felt, they* [Voluntary Drugs Project] *thought* [Statutory Drug Project] *should take me and they referred me to* [Statutory Drug Project]. *Apparently what was supposed to have happened,* [Statutory Drug Project] *was suppose to have sent me appointments, which I never received"* (Tracey).

This is an illustration of the mismatch between an institutional organisation's fixed appointment procedures and inability to follow up missed appointments and a sex workers chaotic lifestyle. Prior to the interview Tracey had registered with a GP whose surgery included a drugs worker. She talked about trying to get a prescription via this route.

It became evident that appointment times restricted sex workers to a certain date and time, this caused difficulties for sex workers, who did not know what they would be doing in the next hour, much less in a couple of days or weeks. It was very clear eleven of the sex workers lived from day to day, a few from hour to hour and they admitted they were unable to make plans. Babs described an informal arrangement with her Psychiatric Nurse, to turn up at the clinic if she needed to see her rather than make an appointment. This was an exception to the normal rigid access explained to be due to the fact that Babs was a paranoid schizophrenic, who had been violently sexually attacked by a client, approximately a year before the interview. She pointed out the police and sexual health outreach worker had made her fully aware of the services available to her after the attack (e.g. counselling, Prostitution Liaison Officer). Nonetheless she claimed to rely on informal contact with the sexual health outreach worker and occasionally saw the Psychiatric Nurse. As Babs acknowledged, the Nurse knew that if Babs had a fixed appointment the she would never see her. As Babs herself admitted, *"I'm terrible to keep my appointments".*

From analysis of the narratives a chaotic lifestyle generally led to a more chaotic use of health care services and 'dipping' in and out of health care provision. For instance Maisie recounted periodically using health services. She had been diagnosed as having severe Post Traumatic Stress Disorder but she was unwilling to talk about the cause. Maisie claimed to have recently decreased her heroin usage, previously a £180 a day habit, but continued to smoke cannabis *"all the time".* She was on a prescription for Prozac and bought methadone from the street, 100 millilitres daily. Maisie, in common with some of the other sex workers, talked about using services not when she was at her most vulnerable, but when she could psychologically cope with talking about her needs. This was particularly true in relation to her appointments to see her Psychiatrist, as Maisie went onto explain,

> *"*[s]*ometimes it's twice a month and then I'll have a really bad problem and can't handle it and won't see him for six months...*[although] *if I need to see him I can... get an appointment I think within a week. When I first went it was like months you know"* (Maisie).

(b) Access Blocked By Important Others

For a few sex workers non-use of health care provision was blamed on the actions of important others. The term important others is used in this study to identify those mentioned previously (e.g. partners, husbands, massage parlour managers) who directly or indirectly affect sex workers' choice of access (e.g. type of service and when used). In this instance they are understood as affecting access, causing sex workers to feel stigmatised, preventing them from fulfilling their right to health care provision by reducing their power and as such decreasing their safety. This confirms the medical and legal discourse relating to the constructs of diminished rights and power, involving stigma and the implications of access on safety as discussed in the theoretical framework in Chapter One.

Tracey recalled a violent sexual assault a year and a half before the interview. Despite the police offering her medical help after the attack, she explained she refused due to the reaction of her ex-boyfriend. After the attack she recounted telephoning to tell him about it, but he had not believed her. If she had gone home she claimed she would have faced a *"further beating"* and would have been sent straight back out to work again. Tracey confirms within her narrative the legal and moral discursive constructs of rights and power. In this instance her rights were diminished, not only had a client attacked her but she also appeared to have no power within her personal relationship. She was vulnerable in both her work and private life. As she continued to explain,

> *"...my ex-boyfriend was a bit pushy and violent and if I didn't go home with money then I would be in more trouble and I basically had to go back to work"* (Tracey).

Polly, on the other hand, claimed to have no experience of physical harm, but felt if she ever did have a work related health need she would have no hesitation in seeking treatment from her GP. However, Polly's husband, who had been very domineering throughout the interview, interrupted at this point saying that he would not allow her to tell the family GP that she worked, as the GP had no need to know. This is an interesting example of power relationships as discussed in Chapter One. To ensure that she complied with his wishes he maintained he would not only make the appointment for her but also accompany her,

> *"I wouldn't tell anybody that you worked, I would go mad if you did and I would go to the doctors with you, they don't need to know"* (Polly's Husband).

Interestingly he stated 'would' which suggests he has not previously accompanied her. His statement indicates that access to the GP is not prevented but the stigma he feels does present a barrier to the scope of narrative with the GP.

Five sex workers who worked in parlours that allowed access to the Sexual Health Outreach Project reported sexual health outreach workers were not allowed into other private premises. Some licensed massage parlour managers were believed to ban sexual health outreach workers from the parlours due to their fear that they would be arrested for running a brothel. Sexual health outreach workers were perceived to be linked by the managers to health needs associated with sexual intercourse, specifically infection, and provide the service of free condoms. The parlours were licensed to sell massages, not sex. If sex was 'not' being sold, infection was not a risk to the sex workers health therefore there was no requirement for Sexual Health Outreach Workers to visit. If they were allowed into the premises the managers of parlours believed this would draw unwanted attention by the police to their businesses. As explained by Katrina

> *"...they* [sexual health outreach] *aren't allowed in parlours in* [the city] *but that's mainly the parlours' fault"* (Katrina).

In some parlours where sexual health outreach workers could not gain access sex workers reported condoms were not allowed on the premises. At one massage parlour there was an alleged *"hiding place"* for the condoms, just in case the police raided the building. As a result it was acknowledged not all sex workers knew where the condoms were kept. Again this was explained as being the result of managers' fear of arrest and prosecution. This provides an instance of the legal discursive constructions of rights (i.e. the right to 'choose') and power (i.e. the ability to exercise that 'choice') as discussed in Chapter One. In the parlour environment sex workers narrative illustrates they had diminished rights in relation to choice of service provision, therefore their vulnerability increased and safety decreased, as their ability to control infection was limited. Katrina identifies this as a huge risk to sex workers' health,

> *"OK you're allowed a licence as a massage parlour but you're not allowed any condoms on the premises - that's dangerous, that's inviting health risks and trouble"* (Katrina).

Sex workers' choice of service provider was often dependant on the flexibility of the service provider with respect to their occupational needs within their chaotic lifestyles. An influence underlying choice and the resultant safety is the economic process of prostitution. Unless the information, advice, contact and supplies are free and increase occupational safety, the service will not be used. Entwined with the economic process are social relations, specifically with the service provider. A trusting, confidential and proactive relationship increases access and thus safety. Social relationships with important others involving stigma decreases access. Traditional biomedical service providers exercise power in the form of access protocols, which are too inflexible for the sex worker, in turn limiting access, increasing stigma and decreasing safety. Many of these influences reduce sex workers' power and limit the use of their rights to health care provision.

A major concern for sex workers creating a further barrier to health care services was the fear of being stigmatised by other service users and service providers. The discursive construct of stigma included notions of respectability and differentiation.

2. STIGMA AND ACCESS

Fear of being stigmatised by health care providers was understood to constrain the choice of service provider the sex workers approached and accessed. Sex workers believed the sexual health outreach workers treated them with respect and did not negatively judge them for selling sex. Babs reported relying heavily on sexual health outreach workers, and Maisie when talking about her drug use and sexual health was very clear that she only used the sexual health outreach workers and in turn only accessed her psychiatrist via them,

> *"I don't use anything apart from seeing* [sexual health outreach worker]*"* (Maisie),

> *"...they said I could go to counselling but I don't want to. I got* [sexual health outreach worker] *anyway to talk to"* (Babs).

The narratives indicate that despite complex health needs some sex workers did not access biomedical service providers to use health care provision. They identified stigma as a major obstacle in their choice of, and actually seeking health care services. For instance sex workers discussed being fearful of what they might be told in relation to having caught an STI as they would be stigmatised for not only being a sex worker but a sex worker with

an infection. Sex workers believed stigma was attached to the questions they would be asked in relation to how they caught the infection and who their sexual contacts were. If sex workers answered the questions they feared they would be treated differently but also feared the information recorded on their medical records or in police notes would lead to future stigma. Sex workers blamed themselves for not being emotionally strong enough, a prerequisite of sex work, to ignore the attached stigma and access health care services. Their inability to access health care services illustrates the extent of the effects of the moral discursive constructs attached to sex work. Some sex workers were able to resist the negativity of the discursive construct of stigma in relation to pollution and safety as discussed in Chapter One but for other sex workers interviewed their social and gender vulnerability made this difficult. Despite Queenie saying that she would visit the clinic immediately if she felt her health was at risk, it had taken her several weeks to build up the courage to go to the GU clinic when she thought she had Hepatitis. As she herself admits, stigma attached to being a sex worker with an infection and the reaction of her family, resulted in her taking several weeks to talk to a sexual health outreach worker. She went onto explain,

> *"I was really panicking talking to my friend, what do you think I should do? ... I kept on putting it off and finally got myself up there* [GU]. *I was scared"* (Queenie).

As the following quotations illustrate, stigma attached to prostitution played an important role in sex workers' relationships with their GPs. Maisie, Cath and Summer believed their good relationship with their GP would be ruined if the GP knew they sold sex. They claimed the boundaries they created between work and home, mother and sex worker would be blurred, their families may find out or be stigmatised by being associated with a woman who sold sex. Maisie, Cath and Summer went onto say,

> *'*[b]*ecause they* [GP practice] *are quite snobby and they help me with a lot of problems, they know that I've done it* [prostitution] *in the past but I don't want them to know about it now as I'm quite close to my GP"* (Maisie),

> *"...*[m]*y family goes to that doctor as well and I just, even though it's all confidential, it's just far easier to go somewhere else"* (Cath),

> *'*[n]*o I wouldn't because he is the family GP and there is no way I would, as I say my life outside this building* [parlour] *is totally separate"* (Summer).

Diane and Dee felt that telling their GP that they worked, or going to the GP for sexual health needs would make no difference, as the GP would send them to the GU anyway. Therefore, they believed they would gain nothing in telling the GP or going to the GP for work related health care and possibly subject themselves to stigma. The majority of GPs were perceived to have very little understanding of the risks selling sex from the streets posed to their health, and within the lifestyle what was possible and what was not (e.g. finishing long courses of antibiotics).

Sex workers identified two important aspects of the discursive construct of stigma, respectability and differentiation. Both will be explored in the following section.

(i) Respectability

The concept of respectability was interconnected with the way in which sex workers constructed health needs and risks to health within notions of responsible and irresponsible behaviour as discussed in Chapter Four. Respectability was linked with responsible behaviour (e.g. safer sex, safer injecting practice, not using drugs). Although aspects of responsible behaviour still have stigma attached, it is not to the extent attributed to irresponsible behaviour. The sex workers understood themselves to be perceived as not respectable by *'normal'* non-sex workers. Due to the perceived lack of respectability, sex workers explained themselves to be fearful of approaching strangers who were obviously not clients due to the possibility of physical and verbal abuse. Sex workers narratives illustrated that abuse was understood by them as driven by moral, medical and legal discursive constructs of pollution, stigma and power as discussed in Chapter One. Due to distrust of strangers, sexual health outreach initiated contact with sex workers. Angela and Diane talked about their first contact with the sexual health outreach workers,

> *"I've known* [outreach worker] *for 4 or 5 years, they were walking around down on the street handing out leaflets and durex and stuff"* (Angela),

> *"...bringing the condoms round when I first started working...I saw them and they come up and I didn't know nothing about it till then"* (Diane).

Sex workers believed earning money by prostitution was perceived by 'others' to make them less respectable with limited rights but some also used drugs and were addicted to drugs, adding to the moral discursive construct of pollution and 'polluted' womanhood. Sex

work and drug usage led to stigma decreasing the choices made in relation to seeking health care. Seven of the sex workers discussed a drug addiction that had taken over their lives. Ebony who was heavily dependent on heroin described how her drug use dictated how she lived her life, starting from when she first got up,

> *"*[y]*ou're getting up in the morning knowing you have to go out, spending an hour or two looking round for stuff to take to the pawn shop, pawning your stuff, finding where the dealer is, picking it up* [the heroin]*, taking it back* [to the flat]*"* (Ebony).

The sex workers believed stigma and respectability were connected with the disposal of used injecting equipment. Ebony had weekly contact with the sexual health outreach workers for clean needles and condoms. To reduce stigma she explained she had her own Sharps Bin at home that the sexual health outreach worker delivered and either picked up or Ebony would take it back to the sexual health outreach building when full. Even though the drugs were habit forming and involved the use of a needle, Ebony assumed having clean needles and a Sharps Bin was respectable and responsible drug use. For Ebony a Sharps Bin at home saved her the embarrassment of having to take her 'dirty' needles into a needle exchange in a designated chemist. As Ebony explains,

> *"*[t]*hey* [the chemist staff] *will not handle the needles, you have to put them into the box yourself which can be a little humiliating standing in the middle of the chemist"* (Ebony).

Nonetheless Maisie claimed her drug use was respectable and responsible, as she had no need to have a Sharps Bin at home. For Maisie a Sharps Bin at home represented a large irresponsible uncontrolled drug addiction. Despite having contact with the sexual health outreach team she described obtaining her clean needles from the chemist and took her used needles back to the chemist. Maisie did not find this stigmatising as Ebony had, because for Maisie it illustrated respectable drug use. She felt she had no need for daily supplies of a large number of needles so her usage did not warrant a Sharps Bin as she states *"I wasn't fucking six needles a day"*. These narratives illustrate a clear resistance to the perceived negativity within the moral discursive constructs of stigma, safety and pollution as outlined in Chapter One. They both admit to using drugs and although their behaviour differs, both challenge within their narratives the construct of being a physical 'pollutant'. They believed they were 'safe' due to undertaking personal responsibility and possessing an increased awareness of risk, and thus not deserving of stigma.

For Queenie stigma and respectability were interlinked with not so much having caught Hepatitis but in the way that she could have caught the infection. Illustrating that if an infection was caught there was a respectable way in which it could be explained. Queenie admitted she did not know whether her ex-boyfriend shared needles but explained him catching the infection through *"fucking around"* when she was in prison. She discussed openly having unprotected sex with her ex-boyfriend, which she identified as the way in which she had caught the infection. She was adamant that she never shared needles, spoons or filters with her ex-boyfriend and as the following quotation shows she went to great lengths to tell me this. For Queenie sharing needles was not responsible or respectable behaviour but represented contamination and shame constructed in terms of 'pollution' and stigma within moral and medical discourses,

> *"*[w]*e never shared the needles...you know I was 100% never share a needle, never would share a needle. I've got my kids to think of..."* (Queenie).

Queenie seemed unaware of the underlying dichotomy concerning her understanding of risk to health; she would have unprotected sex with her injecting drug addicted boy friend but would not share a needle with him. This behaviour is related to compartmentalisation of home and work life but intertwined with respect that has clouded her ability to consider health risks (e.g. condoms are related to work, trust is associated with non use of condoms within behaviour of 'normal' respectable people in long term relationships, 'normal' people do not use or share needles).

(ii) Differentiation

The stigma of being seen as different from non-sex workers was a concern that limited the use of health care provision by some sex workers. Reasons given by sex workers for not using health care provision were people *'guessing'* what they did for a living, followed by their negative reactions. Due to the moral discursive constructs attached to sex work outlined in Chapter One, it became clear from their narratives that sex workers felt powerless to resist stigma in certain situations (e.g. busy waiting room). Summer claimed to have used the GU only once and had been accompanied by the sexual health outreach worker. Due to her perceived reactions of other people she had found sitting in the main waiting room very difficult to cope with. One way in which Summer described separating her work and private life was the way that she dressed while working. As such she believed she was dressed *"respectably"* when she attended the GU clinic, however,

> *'[y]ou go in and sit down and there are all these couples and it doesn't matter what state you are dressed in they nudge each other and look"* (Summer).

She felt other service users should not treat her differently from non-sex workers. Summer felt that she would find it more comfortable sitting in a separate waiting room even though this would separate her from non-sex workers, increasing the difference she wanted to reduce although positive differentiation would reduce stigma. She did say, however that if sex workers got there at a start of a session they would be taken straight through to the consultation rooms if the staff were not too busy while everyone else was filling in their forms.

Some sex workers reported being treated differently to non-sex workers by service providers therefore limiting their use of health care. Abby claimed,

> *"I told one female doctor up there* [GU] *that I worked and immediately her attitude changed and that felt quite uncomfortable"* (Abby).

Abby was upset about the consultation because she felt the doctor was making judgements about her ability to contact all her sexual partners if she had an infection. Abby was adamant that she would be able to contact her clients and felt judged by someone who due to her job should be more accepting of other people's lifestyles, especially as Abby recognised the doctor as holding a position of trust. Experiences such as these, subjecting Abby to stigma, had caused her to limit her choice and use of biomedical service provider. For Abby it did not matter if people knew that she had been a sex worker as long as they did not behave any differently from how they would with a non-sex worker seeking health care.

For a few sex workers they imagined male service providers would think differently about them when compared to non-sex workers. The majority of the sex workers interviewed did not trust men. Dee described how she believed that every man who passed her when she was working even though they might not be looking for business would imagine what she would *"...look like naked and what she was like in bed"*. These feelings of distrust applied to male service providers as well. For instance Dee believed,

> *"[a]s professional as he might be, if he knows what I do for a living thoughts might just flick through his head in a split second then I've lost all faith in him"* (Dee).

If the male service provider knew Dee was a practising sex worker she claimed she would treat the service provider differently. She would be wary of him and also find discussing personal problems difficult due to the fear that he was seeing her as a sexual object rather than someone who needed advice and treatment. Despite the fact that she acknowledged that this may not be the truth, she felt that her job gave him the excuse to do this. Cath was wary of any service provider, whether male or female, who did not have contact with the sex industry as they might have negative perceptions that would impact on the way that they behaved towards her. Her narrative illustrates that it was a perceived lack of understanding of their lifestyle combined with the medical, moral and legal discursive constructs of pollution, safety and stigma as discussed in Chapter One that led to the possibility that sex workers might be treated differently. Both Dee and Cath believed being constructed as a sexual object compromised and diminished their rights to advice and treatment. However, Cath acknowledged that the GU clinic did know that she worked and as such were able to ask appropriate questions without being seen to pry or judge. She felt the GU service providers could frame the questions to take into account that she worked, without offending her, thus treating her differently from non-sex workers but differently in a positive way. As Cath explains,

> *"...if you go to your doctor they know your name and they'll sort of look at you as if to say that you are strange doing this job...whereas if you go there* [GU]*...you can keep yourself to yourself and they won't ask questions"* (Cath).

Abby had felt differentiated against and stigmatised by the GU service providers. Whereas, despite Summer feeling stigmatised by service users claimed she had gone to the GU clinic and had been *"...treated no different from any one else"* by the service providers. When asked why this was important she replied *"...after all we're human beings"* implying that sex workers were not always treated as such, confirming within her narrative the moral discursive construct of stigma and the sex worker as 'other' as discussed in Chapter One. Abby and Summer recount two very different experiences of the same service provider although Abby was an exception, being the only sex worker to recall having a negative experience while visiting the GU clinic.

The fear of others finding out how Maisie earned a living and becoming known to the police for prostituting stopped her from seeking medical help after being abducted and physically assaulted. Maisie explained she did not want to be *"an easy"* target in the future for arrest or have a criminal record. Her narrative confirms the negative effects that criminal legislation has on the sex workers lifestyle, in this instance decreasing her safety, legal rights and power, as examined in Chapter One. She did not want to be subjected to stigmatising behaviour through differentiation so had not sought medical help as she indicates,

> *"I didn't want anyone involved with what had happened because it would come out 'why were you with him?' and I didn't want anybody knowing that I was a prostitute"* (Maisie).

Due to the stigma from negative differentiation many sex workers reported not telling their GPs they worked. They claimed it would automatically be recorded on their medical notes so when they stopped working the information could be seen by anyone who had access to the notes. They were concerned there would no end to the negative differentiation caused by sex work. Nikki described going through the assessments for a sex change and was waiting to hear if the health trust would authorise the operation. For her the fact that she had been a sex worker in the past was a *"well kept secret"* from her GP for fear of her *"shrinks"* finding out. If the psychiatrist did find out that she had previously worked, Nikki believed that they would see her as undeserving, even more different and stop both her medication and the proposed operation.

A couple of the sex workers interviewed did not feel that they had been dramatically affected by stigma attached to sex work. They did not care their GP knew as they perceived it made no difference in their lives and due to drug use and their mental health needs they were unable to *"keep it a secret"*. On the other hand a few sex workers had made a conscious decision to tell their GP as they believed if the GP did not know they worked it would affect their quality of care. In these instances difference did not directly result in stigma. Lou explained using her family GP for both work and non-work health needs and she claimed the GP was fully informed that she worked. She did however, realise that not all GPs were as sympathetic as her own towards sex workers particular if they took drugs,

> *"[h]e will fight for his patients and it doesn't matter how expensive the treatment you will get it if he thinks that you need it, there again they are in the minority. There are other working girls who have GPs that won't help them"* (Lou).

Knowing the health provider had contact and treated other sex workers added to the reasons why they chose and used the health care service. No stigma would be attached and they would not be treated as different. As the health providers had contact with other sex workers they felt the service provider would not be so 'shocked' or judgemental regarding how they earned a living or the nature of any health needs they had. The sex workers believed the service providers would also have the necessary understanding of the health needs and risks to their health. Of the sex workers who used the GU they had either told the staff directly that they worked or felt that it was unnecessary and implied, as a sexual health outreach worker had accompanied them. Babs who had been an intermittent user of the GU clinic, believed the staff at the clinic had extensive knowledge and experience of sexual health needs and as such,

> *"I don't get embarrassed up there cause I think that they see so many* [working] *girls anyway"* (Babs).

Sex workers' choice and use of health care services was influenced by the stigma they perceived was attached to respectability and negative differentiation. They believed the public and some service providers view them as not respectable and different. Their narrative illustrates that this can be attributed to the negativity within moral and legal discursive constructs, examined in detail in Chapter One. The sex worker is constructed as a 'polluter', contaminating their community, reducing their own and others' safety, and thus not deserving of respect; different, to be stigmatised. They need to feel respected and considered 'normal' so they are not stigmatised, increasing use and choice of health care services. To minimise stigma in relation to infection and feel respectable they follow occupational responsible behaviours. Perception of stigma from service providers has been influenced by the social relations they have with service providers. It is not clear from the narrative what the underlying influence determining their knowledge of respect is but most probably from schools, family, media, and religion. Differentiation was constructed in a negative way resulting in stigma reducing choices and use of health care services. However, despite wanting to be acted upon as 'normal' positive differentiation was accepted and was believed to improve their choices.

3. POLLUTION

Underpinning both safety and stigma is the discursive construct of pollution as discussed in Chapter One. The sex workers wanted access to health care services, which would keep them 'safe' from being infected by the client and 'safe' from infection during the process of taking drugs.

(i) Sexually Transmitted Infections

Sex workers felt at risk of infections during the sexual exchange with clients, they resisted in their narratives the moral and medical discursive constructs of the sex worker as a 'pollutant', clients were the 'pollutant', not sex workers. This underpinned the choices sex workers made in relation to the type of and circumstances under which health care services were sought. Nonetheless STIs became more of a risk with partners outside work, as condoms were not always used and did not attach the same connotations of irresponsibility and blame as non-condom use with clients.

For a few sex workers infection necessitated an appointment for treatment usually at the GU clinic. An appointment was understood as a necessity due to the signs and symptoms of an infection or due to notification that a sexual contact had put her health at risk from an infection. The sex workers felt they should have known better so avoiding the infection. Having an infection they felt reinforced the stereotype that all sex workers were unclean and therefore 'polluted', increasing stigma. If a condom split, which sex workers apart from Diane stated rarely occurred, some said they would go straight to the GU clinic, others that they would wait for three months before going. This illustrates the differences in knowledge and what different sex workers saw as a risk to their health.

The most common type of infections that sex workers reported visiting the GU with were Thrush and Cystitis. Angela complained of these STIs almost continually since she started work seven years previously. She claimed the rubber of the condoms and the numerous sexual exchanges caused soreness and irritation. However, she admitted it was only in the week before the interview that she had gone to the GU clinic for an examination. Before this she described using her GP who she had not informed that she was a sex worker due her belief that he would not treat her, and this would reduce her choice of service provider. Despite *"courses and courses of tablets"*, she stated the Thrush and Cystitis had been getting worse. One of the sexual health outreach workers had booked the appointment and

taken Angela to the clinic, she was due to go back to the clinic a week after the interview so that the clinic could *"...look at the problem and try and find out what it is"*. If Dee had,

> *"...any personal problems I always go to the GU clinic rather than my GP because I can be totally straight with them and not have to worry, so they are fully aware of what I do and the risks involved"* (Dee).

Babs recounted starting to work on the streets 20 years ago with very little knowledge of 'safe' sex and had consequently caught an STI. The carrier of the infection could quite easily have been her husband as she admitted he had been unfaithful to her when they were together and had *"caught something"* before. Despite the behaviour of her husband she blamed the source of the infection on clients whom she had picked up from the street as,

> *"...when I first started working the street I didn't know how to use a condom so I caught VD...it was only because I had just started working and I had no idea"* (Babs).

Babs went to the GU clinic to have treatment because she believed they would not act upon her as though 'polluted'. Queenie confirmed that if she was concerned her health was at risk she would visit the GU clinic because she felt they understood STIs without judging her lifestyle,

> *"*[n]*o I've been lucky* [condoms have not split] *I don't know what I would do if anything like that happened I think I would be straight up the clinic"* (Queenie).

The sex workers who did not seek help after a condom split or after a sexual attack, were the same sex workers who reported not having regular contact with biomedical health care services in their day-to-day life. For example Liz admitted never visiting the GU and acknowledged she did not have a good relationship with her GP. She claimed that, on one occasion, while working a condom had split. As the following quotation will illustrate, at the time of the accident her concerns had been infection and pregnancy. Liz was one of only two sex workers interviewed who mentioned pregnancy as a possible result of a split condom,

"[o]nce I did have a problem with a condom bursting but I hoped for the best, hope that he didn't have anything and I didn't get caught pregnant. I was too afraid to go and see about any disease or anything" (Liz).

Liz did not seek medical help but described waiting until the start of her period, when it was obvious that she was not pregnant. She did realise that infection was still a possibility, and even though she worried about having some kind of infection, and rationalised that the GU clinic would probably tell her she was *"clean"*, thinking that she might have an infection was preferable to being told. She would prefer not to know if she had *"anything"*. The use of the word 'clean' may imply that catching a work related STI made her feel 'unclean' which resulted in self-blocking access to health care. The perceived effects of the moral discursive constructs of pollution, as outlined in Chapter One governed Liz's behaviour, specifically 'polluted' womanhood.

At least three of the sex workers did not construct themselves to be a risk, 'a polluter', but they considered every client to be 'polluted'. They believed infection from clients while working was not a risk to their health. As such use of biomedical service providers, specifically regular visits to the GU for blood tests and internal examinations were explained as unnecessary. This understanding directed their choice of health care, to preventative service providers. Sex workers believed they were 'clean'. Infection was not understood as a concern because they were careful (i.e. followed responsible behaviours) while working or were selling services that did not involve sexual penetration. Polly described selling sexual services that involved domination so she had never thought of the having to use services that dealt with STIs. May reported having her last health check at a London clinic for sex workers three and half years before the interview. She claimed not to have had any condoms split or leak during this time and combined with the rules that she had with her clients (e.g. condoms at all times, no kissing, no oral) she did not feel the need to have a sexual health check up. The only time Lou acknowledged using the GU clinic in eighteen years of working was to have HIV tests before she had children. Even then she justified using the GU clinic rather than her GP because the GU clinic is the only health service that can do the blood tests for HIV/AIDS. Lou did not consider that she had *"been at any major risk"* of infection to necessitate a visit to the GU clinic. Their narratives resisted the discursive constructs of sex workers as physically 'polluted' as discussed in Chapter One. They described taking personal responsibility for their behaviour and as such believed they had the power to protect their health and be 'safe' from infection.

For some sex workers the need to talk to the sexual health outreach workers or to visit the GU clinic if a condom split was explained to be dependent on the reaction of the client. The sex workers claimed their anxiety would be reduced if a client was *"panic stricken"* after the condom had broken. The sex workers would work on the assumption that he was worried about catching something from them as opposed to passing an infection on to the sex workers. This is an instance of the sex workers' narrative illustrating acceptance of the perception that they are a source of infection (e.g. a physical 'pollutant') rather than resisting the construct, and using it to determine their own safety and health care choice. The clients' anxiety reduced the sex workers' concern of infection until it was time to visit the GU for their next test.

For a few sex workers *"peace of mind"* (Cath) was important as although they claimed not to undertake risky behaviour and had no symptoms of infection they visited the GU clinic regularly. If they did have an infection they believed it could be treated in the early stages without further risk to their health. When infection was a concern, the GU was a health care provider that offered a general health *"MOT"* as described by Dee,

> *"*[t]*hey have a look, take a couple of swabs, take a blood test and ask me a few general questions about urine, they take a urine sample and that's about it really"* (Dee).

Sex workers chose the GU clinic as the biomedical service provider because they considered the GU had the knowledge and the facilities to undertake such tests to reassure them they were not infected (i.e. 'clean').

Despite the risk of infection Abby admitted that when she first started working on the street at 13, her main concern was earning the money for drugs. Her needs were immediate, stopping the symptoms of withdrawal. She had not known of the GU clinic and even if she had known she admitted that it would not have made any difference to her behaviour. Sex workers with severe mental health needs and drug addiction had chaotic lifestyles, which did not or could not encompass the use of health care services. Thus 'pollution' influences had little or no effect on their choice and access.

When sex workers were asked the frequency of visits to the GU clinic the majority stated that they used it every three to six months, six months at the very least. They visited the GU

clinic *"out of habit"*. Even so some of them contradicted themselves as the interview progressed. For instance Summer said that one of the conditions of her working in the parlour was that she went to the GU clinic every three months. However when talking about her experience of going to the clinic towards the end of the interview she said that she had only been there once. This was despite the manageress of the parlour where Summer worked claiming that regular visits and check ups at the GU clinic were a condition of employment as the following quotation explains,

> *"[t]hey're not allowed to work for me unless that get tested, the lot everything, right the way through"* (Katrina).

The next section will discuss how the extent and type of drug use affected what sex workers told service providers and the health care services used.

(ii) Drug Usage And Health Care Services

Sex workers believed admitting to drug use subjected them to further stigma from service providers; they would be acted upon as though doubly 'polluted'. For Gillian the stigma and notions of unreliability attached to people that use drugs were used against her in a rape trial. She described how her father had raped her resulting in a subsequent court case. To make her out to be an unreliable witness, Gillian explained how the defence lawyer had used her history of drug addiction, which resulted in the case, being dismissed. Consequently Gillian kept her sex work life separate from her private life when seeking advice on and care for health needs. She believed the fact she was a sex worker was not any business of the GPs, as in the past honesty concerning her drug use had been used against her. In this instance 'pollution' in terms of drug addiction affected their choice of how to use the service provider.

Abby and Belinda were among a few of the sex workers who reported having difficult relationships with their GPs. Both explained their doctors' behaviour in terms of stigma and prejudice attached to drug addiction rather than sex work per se. Abby had recently changed surgeries but she claimed her old GP always blamed whatever health need she presented him with on her drug addiction,

> *"I went into renal failure last year and I was really ill, I went to the doctors surgery and he sent me home again because it was put down to drugs. Everything that was wrong with me was because I was taking drugs"* (Abby).

For Abby it was not only that the GP categorised all her health needs as drug related but also that her drug addiction became a reason for treating her differently from other non-drug using sex workers and in particular withholding appropriate services. Abby explained that she,

> *"...didn't get on with him* [the GP]. *I felt that he looked down on me, talked down to me and just thought I was scum"* (Abby).

Belinda blamed the stigma attached to drug users for the negative attitude that her new doctor and surgery receptionists showed towards her and again not the fact she was a sex worker. Belinda had told her GP that she worked because many of her health needs (i.e. depression, increased speed usage, suicide attempts, anorexia) were exacerbated by sex work and due to her mental health state it was easier to tell him than try to hide the truth. She claimed to have worked hard to gain their respect,

> *'*[s]*o it's Dr* [name] *now but he is a cantankerous old git, he don't like junkies but mind you I have to give him his due he is being better towards me...but I'm the only junkie up there that hasn't caused no trouble. When I first went to that surgery the secretaries used to treat me like shit. I had to prove myself but now they call me by my first name and everything"* (Belinda).

Sex workers perceived that some service providers, specifically GPs, considered them in 'pollutionary' terms, especially when drug addiction was involved. The sex workers' narratives illustrated that they tried to resist the discursive constructs of pollution and stigma as discussed in Chapter One by exercising their right to choose another service provider who they felt would not stigmatise them by their attitudes or by trying to prove they are worthy of health care and respect. However, to be able to do this, sex workers had to possess the power to act, and as discussed in Chapter One social and gender vulnerability made this difficult at times.

(a) Reducing Drug Use: Reducing Pollution

Sex workers realised drug addiction treatment would restore control over their lives, increasing their choices, reducing one aspect of being a 'polluter' and the resultant stigma

they experienced. Despite the stigma and notions of unreliability attached to drug addiction, of the sex workers who had sought help with their drug dependency, four sex workers described going through various stages of detoxification and rehabilitation programmes. For detoxification the recommended length of stay is six weeks and for rehabilitation the average stay is six to eight months. The sex workers actual stay ranged from seven hours for detoxification to four months for rehabilitation, affected by the type of service users and treatment process. Liz was the only sex worker who claimed to have completed the whole programme of detoxification, coming out 'clean', reducing her belief she was 'polluted'. But she admitted starting to use again three months after her discharge when her sister re-introduced her to heroin,

> *"...she showed me a bag, well that was the downfall ...slowly got back into it, I thought that I could keep control but I couldn't not at the end"* (Liz).

Both Ebony and Abby considered drug rehabilitation had been unsuccessful and both of these sex workers claimed it had caused increased mental health needs (e.g. depression). Three weeks after Ebony had discharged herself from treatment she recounted returning to work on the streets to fund her increasing and diverse drug use (i.e. heroin, methadone, cannabis, alcohol, speed, amphetamines). Before her return to the streets Ebony claimed not to have worked for two years. Abby described being admitted to rehabilitation on two separate occasions. On the first occasion she stayed for four months and the second admission she was there for three months before she walked out. Abby claimed that rehabilitation was unsuccessful for her because it was based on the Minnesota twelve steps programme that relies on *"...your higher power and God and stuff like that"*. Abby found the counselling too intense and invasive as,

> *"[t]hey tried to get what ever they could out of you, it's not at your pace and they are quite good because they know what buttons to push on you"* (Abby).

Four years on from the last admission for detoxification Abby described being on a Methadone prescription, which she alleged she had instigated herself with the Statutory Drugs Project. At the time of the interview her plans were to stay on the prescription for six months and then to go in for detoxification rather than rehabilitation. She explained she had moved out of the red light district and cut all her previous ties with the sex work and drug-using lifestyle. Abby maintained she did not want to be hospitalised while on the prescription as in rehabilitation she felt she was cushioned from real life and as such if she

were to go into rehabilitation all the same problems would be waiting for her when she was discharged.

In trying to reduce their drug use and thus 'pollution' the effect of these treatments and the sex workers choice to leave resulted in an increase in their drug addiction. For instance Ebony previously had reduced her addiction to such an extent that she had stopped sex work but since leaving the treatment programme she now has a larger addiction than when she started treatment and is also back working from the streets to fund it, 'doubly polluted'.

III. CONCLUSION

This chapter has illustrated that sex workers' construction of access and provision from service providers was centred on their occupational needs and risks. Use of health care services was directed by the need to keep themselves 'safe' whilst working and their experiences of differentiation and stigmatising attitudes, interrelated with wanting to be considered 'normal' and respected.

Service provider factors that influenced sex workers' construction of access were; the method of contact and flexibility of delivery location, free supplies and a trusting secure 'safe' relationship in which they could be honest about their prostitution and drug addiction. Sex workers did not want to be negatively differentiated from non-sex workers, or considered irresponsible for their lifestyle within stereotypes of morality, infection and drug use. The fear of stigmatisation led sex workers to maintain different identities to access health care for work related health needs maintaining anonymity (i.e. compartmentalisation). The sex workers were mainly interested in preventative and maintenance services related to their sexual health and drug addiction.

Access was limited by their lifestyle, specifically the chaos, lack of control and unreliability of addiction, their work location, life events based on being in care, sexual abuse and violence, previous experiences of health care and professionals. The viewpoint of respectability exhibited in responsible and irresponsible behaviours impacted upon their choice and access of health care service providers. Access was based on immediacy

because of the temporal construction of need, whereas risk, constructed within a future context based on past experience was down-played. Access was dependant upon their perception and priorities but was limited by important others. Sometimes access was self-blocked because of their inability to cope with accessing provision or provide lifestyle information and their inability to understand the need or risk or articulate it clearly. The combination of these influences is linked to disempowerment of access.

The social relational sources of knowledge that have influenced this construction are other sex workers in terms of their experiences of service providers, health care and stigma, intertwined with their personal experiences of these. Important others are power groups restricting their rights of access. Media influences and childhood experiences from education are also presumed to have shaped sex workers' concepts of respectability within sexual relationships and drug addiction. Respectability reinforced by some service provider attitudes and the viewpoint of the sex worker as a 'pollutant of others' in opposition to the sex workers' position that they are 'polluted by the client'. The underlying influence for those continuing to work is always occupational, the economic process that allows them to survive within their lifestyle. Nonetheless, provision of health information, positive differentiation and the support of providers such as Sexual Health Outreach Project empowers the sex workers to access health care provision when they want or need to.

Chapter Seven will analyse the empirical data to ascertain how service providers perceive access, provision and delivery of health care for sex workers associated with their construction of sex workers need and risk. Additionally it will provide an insight into the underlying influences that direct service providers' construction.

Chapter 7

PROVISION AND DELIVERY: SAFETY AND BARRIERS

Chapter Five in fulfilling the second objective identified service providers' perception of sex workers' need and risk explained within a construction directed by underlying influences. This chapter builds on that knowledge to meet the last objective, to identify the provision and delivery of health care services, their construction and the underlying influences.

The discursive constructs of safety, stigma and pollution are constructed by sex workers in terms of drug addiction, damaged mental and sexual health which also underpin the type and level of health care services offered to sex workers by the service provider. Chapter Five illustrated that service providers' construction of sex workers' needs and risks was dependent on the remit and speciality of the project, professional ideologies, personal bias, training and the experience of the interviewee. This chapter examines the extent to which medical, moral and legal discourses govern sex workers' lives, illustrating conformity with and challenges against the discursive constructs of pollution, stigma, safety, rights and power discussed in Chapter One.

Chapter Seven also explores the way in which service providers' decisions on provision of health care services for sex workers are made to reduce risk so keeping the sex workers 'safe' from violence, infection and further mental health damage. 'Safe' in relation to sex workers well being but interconnected with this by keeping sex workers 'safe' from infection they are protecting the general public. The way in which health care services are provided is partially dependent on whether the health care provider constructs the type and severity of need and risk as different from those of non-sex workers. Medical treatment of an infection or problematic drug use was identified as a concern for the service provider as were sex workers' risky behaviours. Due to the chaotic lifestyle of sex workers, service providers acknowledged they had to be pragmatic, corrective medical care had to be secondary to preventive and maintenance, support was provided in an attempt to keep sex workers safer within their lifestyle. These are risky behaviours that service providers believed, were difficult for sex workers to stop due to diminished rights and power relationships.

This chapter will begin by exploring the way in which the discursive construction of safety affects provision and delivery. It will examine provision as either treatment or support and the affects of sex worker reliability and autonomy, concluding by examining the barriers to health care provision.

I. THE DISCURSIVE CONSTRUCT OF SAFETY

The following section will illustrate how need and risk were defined in terms of safety as either a priority for treatment (i.e. biomedical: corrective) or support (i.e. social: preventative and maintenance) and how notions of sex worker reliability and autonomy affect service providers' willingness and ability to provide and make accessible health care services endeavouring to keep sex workers safer. Service providers' wanted to protect sex workers from infection and situations that could arise from the diminished rights and social and gender vulnerability of the majority of sex workers discussed in Chapter One.

1. TREATMENT OR SUPPORT?

Depending on the rationale of the service (i.e. the remit and speciality) and the risk sex workers posed to themselves, there were clear distinctions of provision for health need, as a priority for either treatment or support. In both types of provision the aim was understood within the discursive construct of safety, specifically risk reduction. For instance within biomedical service provision the priority is corrective treatment, whereas within the social care model sex workers would be supported in a less clinical environment. Some traditional biomedical service providers were attributed to using the discursive construct of pollution within their narrative, the 'polluted' sex worker infecting 'innocent others' but none of those interviewed admitted to ascribing to the construct themselves. Other service providers' narrative illustrated extension of the discursive construct of pollution and considered the sex worker to be 'polluted by others', specifically clients. Both biomedical and social models of health care provision will be discussed in the following sections understood in relation to control of infection, reducing problematic drug use and supporting mental health.

(i) Control Of Infection

The majority of service providers constructed sex workers as different from non-sex workers due to the way they earned money, used drugs and worked while under the influence of drugs. The way in which need and risk were identified as different directed the way in which sex workers were treated by the service provider enabling different provision

and varying levels of access to the health care services. Despite diverse constructions of difference health care services, were provided to keep sex workers safer. Safer by reducing risks caused by selling sex and problematic drug use, fundamentally linked to reduction and control infection as discussed in Chapter One.

Promotion of safer sex and being 'safe' from STIs while working was primarily constructed within the use of condoms. The Family Planning and Sexual Health Advisory Service reported issuing emergency contraception and offering advice on all methods of contraception ranging from the pill, intra–uterine devices, injectable and implanted contraception and condoms. When discussing supplies given to sex workers to protect them from being infected by clients the Family Planning Nurse constructed health care services within the need for free condoms and cervical cytology. Based on a historical decision due to overspend, the Family Planning and Sexual Health Advisory Service claimed to issue twelve condoms per person per month. The Family Planning Nurse commented that people were never turned away if they wanted more and this especially applied to sex workers who she claimed were happy to say that they worked when coming into contact with the service. However, she freely admitted the service had little knowledge of the health care services required by sex workers and despite claiming sex workers identified themselves, she was unsure whether they used the service,

> *"...we really don't know, we don't keep statistics...because I don't think that we should treat them any other way than say a 14 year old...we try very hard to be non-discriminatory in any way"* (Family Planning Nurse).

Despite the Family Planning Nurse claiming the Family Planning and Sexual Health Advisory Service was non-discriminatory, Sexual Health Outreach Worker (B) explained negative personal bias remained a problem within the service. Sexual Health Outreach Worker (B) narrative illustrated conformity with the moral discursive construct of pollution, contributing to stigma outlined in Chapter One, sex workers were identified as the 'pollutant'.

On the other hand in the hope of keeping sex workers 'safe' from infection the GU Senior Health Adviser maintained sex workers were actively encouraged to visit and return to the GU clinic. A health care service within which construction of sex workers as different from non-sex workers was understood to ensure preferential treatment within the biomedical model of health care. Difference was identified as more at risk from violence than non-sex

workers, a chaotic lifestyle and their inability to feel 'safe' within a traditional biomedical health care environment. 'Safe' was made sense of in this instance, not from infection or violence but 'safe' from negative attitudes when using health care services thus extending the moral discursive construct of stigma. Difference, which appeared to influence GU health care services in a positive way,

> *"...we are more inclined to give preferential treatment to the sex workers...because of their work we want to make sure they are safe"* (GU Senior Health Adviser).

It was believed that identification and appropriate health care was made feasible as Sexual Health Outreach Workers who were professionally known to the GU Health Advisers often accompanied sex workers. The GU Health Advisers talked of trying to fast track sex workers as they recognised their social vulnerability and the stigma attached to selling sex felt by some sex workers visiting the GU clinic. The ability to prioritise the sex workers in this way was described as an informal arrangement and dependent on the agreement of the medical staff on duty and how busy the clinic was. However, Sexual Health Outreach Worker (A) claimed there was little fast tracking at the GU clinic with the exception of one member of staff who would *"...try and get them in the system a bit quicker"*. The same GU Health Adviser was mentioned by the Locum Drug Worker as *"...being very willing and bending over backwards..."* to accommodate the client.

It was reported discussion had taken place within the GU clinic to make the fast tracking of sex workers a formal arrangement but no provision had materialised up to the point of the interview. The GU Senior Health Adviser also claimed that if it were known that a woman sold sex then she would see a Health Adviser as soon as she arrived at the clinic. Everyone who visited the clinic had the opportunity to see a Health Adviser but for the sex workers it was identified by the clinic to be a priority. The narrative indicates conformity with moral discursive construct of pollution, specifically control of infection, as discussed in Chapter One. Sex workers are identified via GU procedures to be different, in need of preferential treatment to promote personal responsibility and safer sex. The GU Senior Health Adviser believed sex workers had every opportunity to ask questions to relieve any concerns they may have had and leave the clinic fully informed of any need or risk.

To identify difference between sex workers and non-sex workers the GU clinic was reported to be considering identifying sex workers by using a symbol on their notes. This

was a policy that the GU Senior Health Adviser acknowledged would actively identify and further increase difference. She believed the symbol would not make sense to anyone who did not need to know the woman was a sex worker. The reasoning behind this was explained as the medical staff would recognise the symbol and then be aware they were treating a sex worker. It was believed appropriate treatment could then be given without alienating the sex worker by asking inappropriate stigmatising questions. However, this would not be sufficient to counter negative personal bias and could increase stigma. This was an instance of the legal discursive constructions of rights (i.e. the right to 'choose') and power (i.e. the ability to exercise that 'choice'), as both could be diminished. The symbol could take away the sex worker's choice of whom she informed that she sold sex on each visit to the GU.

Differentiation was not only made sense of in terms of prioritising sex workers but in terms of the different type of treatment given to control infection. If they identified themselves as sex workers then treatment was reported to be guided by their working pattern. For instance it was explained that non-sex workers would have a week course of medication for chlamydia whereas sex workers would have one dose of medication that would work within twenty-four hours. The GU Senior Health Adviser was fully aware that due to the sex workers' chaotic lifestyle completing a seven-day course of medication would be improbable and also the infection needed to be treated quickly as,

> *"...we need to be realistic because if they need the money then they are not going to stop working"* (GU Senior Health Adviser).

However, it became apparent in the narratives that historical concerns of the sex worker as 'pollutant' continued, 'polluting' the general population, family and womanhood. Sex workers needed to be 'safe' from infection but in addition by keeping them free from infection public health was not at risk. The GU Senior Health Adviser when asked whether the reason for prioritising treatment of sex workers, was for their health or public health, replied *"...both in all honesty, both, there's no getting away from the fact"*. Sex workers continued to be identified as not only a risk to themselves but also a risk to others. Her narrative despite in part resisting, illustrated conformity with the moral and medical discursive construct of pollution outlined in Chapter One.

Unlike the biomedical health care providers, to access the sexual health outreach project for help, it was claimed a specific need (e.g. sexual health, problematic drug use) was not a prerequisite. They described providing encouragement and support to help the sex worker prevent and receive biomedical treatment for STIs. Initial construction of health needs, as sexual health, facilitated contact with sex workers and from this first point of contact other health needs could be addressed. Health needs, as support, and not purely clinical need is illustrated by the following quotation,

> *"[t]he two key agendas are sexual health and safe sex, and substance use but I think we tend to work that in alongside a lot of emotional support to the women, practical support"* (Sexual Health Outreach Worker B).

In an attempt to control and keep the sex workers 'safe' from infection Sexual Health Outreach Workers distributed condoms to sex workers on the streets. A few of the service providers interviewed believed the health care service environment was not conducive to allow sex workers to be honest about failures to use condoms during the sexual exchange. The HIV Advice Worker felt sexual health outreach needed to do *"...some real in–depth work"* with sex workers on sexual health instead of *"patrolling"* the streets handing out bags of condoms. She felt giving out numerous condoms with the expectation sex workers would always use them was unrealistic and reinforced the *"good girl, bad girl scenario"*, 'good girls' use condoms 'bad girls' do not, thus increasing stigma as discussed in Chapter One. So when sex workers were unable to use condoms (e.g. incapacity due to drugs) she believed sex workers felt they only had themselves to blame. Behaviour, which she thought sex workers felt, would be negatively judged if they were honest about their non-use of condoms due to the expectation of their use when they were freely available. This was blame and stigma constructed within moral discourse and unintentionally increased by education that sex workers with diminished rights and limited power found very difficult to resist.

Service providers believed safety was increased and infection controlled by providing health care services, which enabled reduction of problematic drug use. This, service providers believed, would in turn give sex workers the ability to exercise 'choice', to regain some power and control within their lifestyle and believe in their right to be 'safe'. The next section will discuss these issues.

(ii) Reducing Drug Use: Increasing Safety

Reducing drug use was identified as one of the primary aims of some of the health care services offered by the service providers to keep sex workers 'safe'. This, service providers believed, increased sex workers' ability to negotiate the sexual exchange, reducing the risks associated with working from the street while taking drugs (e.g. violence, STIs). Health care services dealing with problematic drug use were guided by different remits. Service providers working within the biomedical model of healthcare made sense of health needs within a rigid definition relating to problematic, dependent drug use within which the priority was corrective treatment. Drug use was described as problematic by service providers if using drugs interfered with *"normal"* daily activities (e.g. holding down a job, taking care of children). If drug use was unproblematic as defined by the Statutory Drug Project they considered there was neither a need nor a risk, therefore no requirement for biomedical health care services. The Consultant Psychiatrist stated,

> *"*[t]*he treatment need, it's a substance misuse service so first of all the treatment need is about a problem about dependency on an illicit drug"* (Consultant Psychiatrist).

Assessment of health need was rigidly defined by the Statutory Drugs Project, for instance the Locum Drugs Worker explained qualification for particular treatments was formally dependent on the amount of heroin taken by the drug user. To have such a distinction is interesting when dealing with complex circumstances involving problematic drug use. The Locum Drugs Worker believed setting limits are *"...all nonsense"*. She made sense of health needs associated with drug use on whether the drug is smoked or injected, how the individual is financing the habit and the way in which the drug use is affecting their ability to assess dangerous situations. Health needs were, therefore, constructed not solely on the amount of drugs taken.

The discursive construct of safety as discussed in Chapter One, involving problematic drug use and risk reduction directed the Statutory Drug Projects response to need and risk which was constructed within a biomedical framework providing corrective treatment via prescriptions for substitute medication. The main substitute medications they listed as dispensing were methadone elixir, injectable methadone, diamorphine, and dexamphetamine elixir. The Consultant Psychiatrist claimed to be the only person in 'Old Port' who held a licence to prescribe diamorphine. In addition if required the doctors at the Statutory Drug Project would prescribe medications to treat psychiatric illness or psychological problems. The Consultant Psychiatrist stated she dealt with clients whose

problematic drug use was particularly complex or when there were indications that specialised treatments such as the diamorphine injections, treatment of difficult stimulant use or specialist detoxification regimes were required.

The Consultant Psychiatrist claimed reduction of risk was not solely treated by a prescription for substitute medication. She explained protection against increased or varied drug use was aided by, for instance, the client addressing literacy problems, sorting out housing benefit and rent arrears and engaging in further education (i.e. social model). Her narrative touches on the legal discursive constructs of rights and power as discussed in Chapter One. In addressing these issues she believes the client would be more aware of her right to 'choose' a certain course of action and have the power and the ability to exercise that 'choice'. However, as she admits and is illustrated by the following quotation the Statutory Drugs Project was constructed by medical staff and service users as primarily a biomedical health care service, which provided substitute medication,

> *"*[w]*e are not just meaning a prescription which is a mistake that a lot of people make about drug treatment agencies...even a lot of the clientele still seem to see it this way and I think that there are a lot of individuals both staff and clients of whom it's easier to see it that way..."* (Consultant Psychiatrist).

The Locum Drugs Worker confirmed, due to the professional staff mix of the Statutory Drugs Project being medical, the service was perceived by clients as more of a biomedical service. Service users identified the Statutory Drugs Project as a service, which treated medical needs located around problematic drug use via substitute medication. She explains the Statutory Drugs Project was not constructed within a social model offering a holistic approach to stabilisation and reduction of drug use and thus,

> *"...we don't have counsellors, we don't have any acupuncturists, we don't have a social worker"* (Locum Drugs Worker).

It became evident that to increase safety the drug services based on the biomedical model were constructed within a framework of stabilisation and reduction. Treatment to reduce problematic drug use was explained to be carried out either in the community or during a hospital stay. It was understood that when the Statutory Drugs Project accepts sex workers for treatment, a prescription might not be appropriate to start with. If the sex workers' lifestyle was too chaotic for instance to receive a community prescription for substitute

medication, the Locum Drugs Worker described the health care service as working with them,

> *"...to get down to a level before we can do anything about throwing more drugs at the problem or might be that you are going to have to go into hospital and stabilise before we can give you a community prescription"* (Locum Drugs Worker).

The Locum Drugs Worker indicated the treatment aim was for the sex workers' drug use to be, at the very least, controlled. If controlled drug use was not possible then the drug needed to be taken in the safest way possible. Although the narratives resisted the moral discursive construct of stigma and drug user as 'polluted other' as discussed in Chapter One, service providers accepted that drugs were a major part of the majority of sex workers' lives. Service providers therefore constructed the reduction of drug use within the promotion of personal responsibility and increased awareness of risk.

The Statutory Drugs Unit comprised four detoxification beds, three for planned admissions, one for emergency admissions, which facilitated stabilisation and reduction of problematic drug use. The Senior Drugs Adviser described the number of beds as *"a token service"* covering the 'Old Port' area. If any of the beds were free in between admissions then it was claimed the psychiatrist could fill them. Clients were referred via the Statutory Drugs Project and allocation of beds was dependent on an individual's clinical need. Sex workers with problematic drug use were constructed as the same as non-sex working drug users, it was the extent of problematic drug use that was the factor resulting in treatment. However, sex workers were identified by the Senior Drugs Adviser as often being admitted as an emergency *"in urgent need...in a real physical mess"*. Despite the requirement to prove clinical need he claimed that previously *"favourites"* of key workers at the Statutory Drugs Project were prioritised indicating personal bias overriding professional ideologies. The drug users whether sex workers or non-sex workers have a pre admission visit. The Senior Drugs Adviser described the plan of reduction or stabilisation once admitted as based on negotiation, staff experience, what the drug user was taking, for how long and how well the drug user was motivated.

For other service providers using the social model of care, health care provision was understood in terms of supporting the sex workers' health need. Their provision for instance was not outlined as being dependent on an arbitrary calculation of heroin use, but on the

concerns and fears of the sex workers. Health needs, as support, and not purely biomedical treatment is illustrated by the following quotation,

> *"[i]t's very much about offering support really to any women sex workers regardless of whether or not they have substance use issues"* (Sexual Health Outreach Worker A).

The primary concern of the Sexual Health Outreach Workers was understood as making contact with sex workers and if they felt it was appropriate referring sex workers onto the substance misuse agencies. They described attempting to keep sex workers 'safe' within the contextual environment of prostitution until or if the sex workers themselves could make a decision to reduce their drug use, *"it's about building rapport...being plugged in at the right time"* (Sexual Health Outreach Worker B). The sexual health outreach project provided supplies to keep sex workers 'safe' in the realisation sex workers would continue to inject drugs regardless of whether they had clean needles. The narratives illustrate partial conformity with the moral discursive construct of pollution, specifically control of infection in relation to unsafe drugs use as outlined in Chapter One. However, they resist the construction of sex workers as undeserving of help; supplies were provided in the knowledge they would facilitate a drug taking lifestyle. One Sexual Health Outreach Worker drew on her experience with injecting drug users to illustrate risk reduction and the importance of providing clean injecting equipment,

> *"[t]he harm reduction bit is I think...being there for injecting users...people would use* [drugs] *whether they have the clean needles or not...it is understanding the nature of the use and why people use as well"* (Sexual Health Outreach Worker B).

Sexual Health Outreach Workers understood the sex workers' lifestyles were chaotic. This was the reason given for supporting the sex worker by delivering supplies when and where the sex worker needed them (e.g. delivery of needles and sharps bins to their home). They also supported the sex workers when they wanted to talk through drug related issues. Risk reduction in this context was constructed as maintenance of the problematic drug use and prevention of further needs.

(iii) Mental Health

Service providers constructed damaged mental health as a major need and risk for sex workers. Provision encompassed medication, D&R and traditional psychiatric care. Concern was indicated that sex workers' damaged mental health impacted on the

effectiveness of some health care provision, decreasing promotion of personal responsibility as discussed in Chapter One. In addition to this concern many of the service providers echoed the thoughts of Sexual Health Outreach Worker (B),

> *"I don't think services are very good around mental health issues...trying to get people engaged in the psychiatric services are often a non-starter"* (Sexual Health Outreach Worker B).

So not only was provision described as poor, even if psychiatric services could cope with the chaotic lifestyle of sex workers, it was explained sex workers would not engage with the health care provision. Service providers felt that services for mental health needs were the most difficult health care provision to access for sex workers. It was reported that psychiatric care could only be accessed through a formalised referral by a GP and as already discussed sex workers had varying levels of contact with and confidence in GPs. Damaged mental health among the sex workers was explained as not often acknowledged by other service providers and even when it was, service providers felt that there were no effective ways of treating it. Sexual Health Outreach Worker (B) claimed if sex workers did engage with psychiatric services *"...they seem to go backwards rather than forwards"*. She described Community Psychiatric Nurses as non-existent and the HIV Advice worker stated the psychiatric hospital was *"dire"*, being unable to provide appropriate care especially for personality disorders or individuals with blood-borne diseases. Psychiatric treatment was claimed not to be beneficial,

> *"I haven't seen anybody who has benefited from their stay in* [psychiatric hospital]" (HIV Advice Worker).

She believed the staff at the psychiatric hospital had little understanding of issues, specifically confidentiality, which was so important to sex workers,

> *"...things like confidentiality...especially if people are on treatment for HIV or Hep C or issues around blood spillage and the use of bleach* [to prevent infection]" (HIV Advice Worker).

It was evident from the narratives that traditional psychiatric services were seen to be inappropriate for many sex workers due to difficulty in engaging with the services and then high treatment failure rates. In the process of access and treatment it was acknowledged

that sex workers are stigmatised with another label, that of mental illness. The health care services reported as accessed for damaged mental health were not separate provision but interconnected with services dealing with need and risk associated with problematic drug use and sexual health. For instance the Consultant Psychiatrist was placed at the Statutory Drugs Agency and described only treating people who had complex problematic drug use and psychiatric health needs. The two main areas where there is the need for a specialised assessment were described as,

> *"[s]ubstance misusers where there was a question of mental health needs or risk or both, people with mental health needs where there was a question of substance misuse leading to arrest" (Consultant Psychiatrist).*

For some sex workers who had no contact with biomedical services they were depicted as using the Sexual Health Outreach Project instead of biomedical psychiatric health care services. As Sexual Health Outreach Worker (A) indicated *"...you've interviewed one with extreme mental ill health who tends to kind of access us".*

For the drug service providers involved with prescribing substitute medication, sex workers were prioritised by their "*vulnerability*", made sense of in terms of their mental state and the risk of suicide. On admission to the detoxification beds a mental health assessment might be carried out which according to the Senior Drugs Adviser was to *"...ascertain whether they are using chaotically due to madness or drugs".* Aside, 'madness' is an unexpected choice of word for a biomedical professional. Other service providers talked about a classic divide between drug services and mental health services, as claimed by the Locum Drugs Worker *"...mental health know nothing about drug use...".* An interesting observation as the Locum Drugs worker was employed at the same project as the Consultant Psychiatrist, it would have been expected that a degree of commonality would be raised.

According to many service providers within both the biomedical and social models of health care the most appropriate treatment and easiest to access was D&R available at the GU clinic. D&R was described as suitable for damaged mental health from traumatic incidents where Post Traumatic Stress Syndrome was evident, it was explained as not involving rationalisation or interpretation. Service providers understood sex workers' damaged mental health as often caused by childhood abuse and experiences of sexual violence at work, exhibited in symptoms associated with Post Traumatic Stress Syndrome. The service provider constructed damaged mental health within sexual health, as the initial appointment

had to be associated with needs and risks treated by the GU clinic. Sexual Health Outreach Worker (B) classified *"talky"* treatments involving a long course of appointments such as counselling and group therapies as inappropriate for sex workers due to their chaotic lifestyles and she believed many had perfected the act of internalising thoughts and feelings. Duration and frequency of appointments for D&R were explained to be dependent on the extent of the flashbacks that were in turn dependent on the extent of the sexual health need. For instance,

> *"[i]f someone has been raped once and they have a couple of flashbacks to it then I may make two sessions close together then another session when we see what's after that. If someone has a long history of sexual abuse I'll make three sessions close together"* (GU Health Adviser).

The reason given for this level of support during the treatment was to ensure the sex worker remained 'safe' and was able to finish the treatment. Also for many sex workers their whole lives were perceived to revolve around the flashbacks. The GU Health Adviser believed sex workers used a lot of energy to control what was going on in their heads. She gave an account of sex workers using different techniques such as keeping very busy, using drugs and alcohol to block the flashbacks. The treatment was reported to have a fairly immediate effect, decreasing nightmares and flashbacks for the sex workers.

The type, effectiveness of advice given, and ease of access to provision were explained as being reduced by sex workers damaged mental health, limited understanding and inability to retain advice provided. Although service providers attempted to keep the sex workers safer from 'pollution' as discussed in Chapter One, their narratives illustrate control of infection, promotion of personal responsibility and safer sex were difficult. For instance, according to Sexual Health Outreach Worker (A), despite protecting the cervix, diaphragms were not routinely offered to women by the Family Planning and Sexual Health Advisory Service if they were assessed as *"...not well together or well educated".* As this described the majority of sex workers, Sexual Health Outreach Workers recounted not referring sex workers for this service. The actions of the Sexual Health Outreach Workers in attempting to protect sex workers from stigmatising attitudes limited sex workers' access and their right to 'choose' alternative health care providers. Sex workers' inability to retain information is illustrated by the following quotation,

> *"...there has been a few that have been counselled* [on Hepatitis C]*...and yet when I've spoken to them it's almost as if they have never been near the issue"* (Sexual Health Outreach Worker B).

(iv) Reducing Lifestyle Chaos: Improving Health

Within the discursive construct of safety, support was prominent, associated with keeping sex workers 'safe' from infection, problematic drug use and reducing risk to mental health discussed in relation to alternative opportunities. The Sexual Health Outreach Workers described supporting and assisting sex workers attempting to reduce the chaos within their lifestyle (e.g. claiming benefits, obtaining accommodation, arranging health care).

> *"It's really about any kind of area of their life that you feel that they could do with a bit of positive input really, in a non-judgemental, impartial way"* (Sexual Health Outreach Worker B).

Risk to health was understood to reduce with the reduction of hours worked and having stable, clean and 'safe' housing and allowing time to consider alternative employment opportunities. However, success was reported to be affected by bureaucracy involving numerous forms and requiring detailed histories (e.g. employment).

For service providers' following the social model health needs were constructed within a broader definition of support. Service providers' narratives confirmed awareness of sex workers' diminished rights and vulnerability within power relationships as discussed in Chapter One. Many of the sex workers were described as having no immediate family and many of their social contacts in life were believed to be tenuous especially those within the drugs network. Service providers described the networks as untrustworthy with very fragile, not very loyal relationships. They explained trying to provide a sense of stability and commitment, to support sex workers through the bad as well as the good times. This attitude is reflected in the following quotation,

> *"I'm still here I'm not going to trot off, if you relapse I'm still here, whatever you do I'm still here I'm really going to try not to judge you I'm here unless you tell me to fuck off"* (Sexual Health Outreach Worker B).

Interconnected with the discursive construct of safety and influencing the construction of need and risk, as either a priority for treatment or support are the discursive sub themes of reliability and autonomy. These concepts are explored in the next section of the chapter.

2. RELIABILITY

Service providers' provision of health care services was not solely constructed in terms of the extent of need or risk, but underpinned by the sex workers' perceived reliability. Problematic drug use and damaged mental health were linked to erratic behaviour, this unpredictability in turn was understood to affect the sex workers' reliability. The service providers' perception of the reliability of sex workers negatively affected the service providers' willingness to provide health care services, thereby reducing their safety. Unreliability impacted directly on sex workers, when they did not keep appointments or follow treatment plans the success of the treatment was reduced, because continuity was lost, and due to long waiting lists, others who would have benefited from that appointment had to wait.

When the GU Health Adviser practising D&R was asked what proportion of their client group were sex workers they replied *"I have seen quite a number of drug users"*. They appeared to automatically link sex work and drugs so classifying all sex workers whether using drugs or not as unreliable both in terms of keeping appointments and in the success of the treatment. The narrative confirms the extent of the moral discursive constructs of stigma and pollution as discussed in Chapter One. All sex workers are stigmatised due to the belief that they all take illegal drugs which leads to the reduction of their rights. As she explains,

> *"I've wasted a lot of time on drug users and it's not that I'm not sympathetic I really am and I would love to help them more but because I've got so little time to do it I like to know that they are a little reliable"* (GU Health Adviser).

The GU Health Adviser explained treatment was believed to be jeopardised as drugs were understood as cushioning sex workers from exploring their feelings, and for the treatment to succeed feelings had to be accessible. However, if drug-using sex workers were not taking drugs at the time of the treatment they were described as vulnerable and frightened when recalling past traumatic events in turn becoming more unreliable. Sexual Health Outreach Worker (A) claimed, sex workers waiting for D&R were chosen based on their perceived level of reliability and on the proviso that they would turn up for the appointments *"...because they* [appointments] *are like gold dust"*. Those chosen were from sex workers who all suffered from the symptoms associated with Post Traumatic Stress Disorder (e.g. nightmares, flashbacks, anxiety) but classified as reliable. She qualified the choice such that,

> *"I don't suggest it* [D&R] *to everyone...but if they are at a place in their life...and also that I thought that they would keep appointments...so I'm selective"* (Sexual Health Outreach Worker A).

Nonetheless, it became apparent that even when sex workers were identified as *"really reliable"* and arrangements were made by the Sexual Health Outreach Worker to pick them up and accompany them to appointments some sex workers did not attend. According to service providers, for many of the sex workers, taking care of their health was not a priority, in turn increasing unreliability. As the following quotation shows, this was accepted as a fact by all the service providers interviewed, regardless of professional ideologies or personal bias,

> "...*they* [sex workers] *might be quite happy for instance to trundle along with their substance use in the time that we see them, might not want to make changes"* (Sexual Health Outreach Worker B).

Even though sex workers had an infection, mental health damage or problematic drug use service providers reported sex workers found it difficult to think about using a service, acknowledging the extent and effects of the discursive constructs of pollution and stigma. Service providers identified sex workers' priorities to be their short-term health needs such as preventing drug withdrawal rather than long-term consequences that may not even develop. Service providers made sense of sex workers avoiding seeking treatment or advice for need and risk, by understanding that sex workers would then have to think about their lifestyle. They believed many sex workers could not cope with the reality of changing their lifestyle in order to protect their health. In addition service providers' narratives illustrated conformity with the legal discursive constructs of diminished rights and social and gender vulnerability of many sex workers that made it difficult for them to access health care services. Some avoided facing their need and risk by not keeping appointments or following treatment plans,

> *"*[f]*or a lot of people when they are using, thinking about aspects of their health doesn't come into it cause then they have to think about their using"* (HIV Advice Worker).

Service providers understood reliability as being dependent on the extent of chaos in sex workers' lives. The service provider in a secure, comfortable job may label the lifestyle and habits of the sex worker as chaotic, chaos being defined by the service provider. All service

providers claimed reliability was very difficult to achieve if a lifestyle was chaotic. However, notions of chaos give the sex workers leeway, as not many expectations are put on an individual, when others label their life as out of control. For the sex worker in that lifestyle, who may know no other, or who for a long time has not known anything different, it may appear 'normal' as the following quotation illustrates,

> *'[g]enerally speaking, I think very often that it's us that consider their lifestyle to be chaotic, I think some women that I might consider to have chaotic lifestyles actually are going along in a lifestyle that may be so familiar to them...so they wouldn't consider it to be chaotic"* (Sexual Health Outreach Worker B).

The exact meaning of 'normal' and 'abnormal' is defined by the service provider, in part to justify intervention, but also to try and understand the different sex worker lifestyles, so improving provision and delivery to keep sex workers 'safe'. In addition, service providers draw on professional skills (e.g. training, experience) to identify infection, mental health damage and problematic drug use, in the context of the lives of the sex workers. The professional skills were based on professional ideologies and familiarity that lead to either a positive or negative attitude towards sex workers. Service providers claimed reliability improved if sex workers facilitated a change in their lifestyle resulting in increased access and thus safety. They explained sex workers have to be at a point in their lives when they are able to think about the effects of selling sex, their problematic drug use, to be able to recognise and prioritise need and risk they previously ignored in order to effect change. The events, which might trigger change, are not minor as the following quotations demonstrate,

> *"...life events, you know the usual events marriage, birth, deaths, convictions, illnesses, changes with relationships, somebody significant finding out from GP to granny"* (Consultant Psychiatrist),

> *"...very often it will be something like a life changing incident to make somebody think right I don't want this anymore, it doesn't feel right, this doesn't feel good for me any more and I want to stop it or I want to change it"* (Sexual Health Outreach Worker B).

Service providers realised the access rights of the sex worker where limited by reliability which was interconnected with autonomy and power, playing a further role in influencing the provision of health care services.

(i) Autonomy, Rights And Power

There are different levels of autonomy within the sex workers' lifestyle. At one level they lack autonomy due to problematic drug use, being powerless to their addiction, powerless to oppose important others and disempowered through damaged mental health. They have diminished rights and are socially and gender vulnerable as outlined in Chapter One. At another level some sex workers have a degree of power to be autonomous within their lifestyle, to prioritise need and risk, improve or reduce their access and thus their safety. As discussed in Chapter One these sex workers believe prostitution is a sexual service, a contract between two consenting adults. Service providers believed sex workers' lives lacked autonomy and power, they considered autonomy within the health care relationship as a positive aspect on sex workers lives, if it could be influenced and supported to improve their health.

Lack of power underpinned by low self-worth as shown in the following quotations,

> *"...she's got a useless, fucking slob of a boyfriend who also has a drug habit, so she goes out and she can't leave the street until she has earned £200"* (Locum Drugs Worker).

> *"...it is quite sad...for a woman to say that I was attacked, I had my money taken or even that I was raped but that's alright I'm alright now as if it is hardly anything"* (Sexual Health Outreach Worker B).

Service providers understood sex workers, as with any individual, have to recognise they have a health need and risk requiring treatment and support. It was explained sex workers also have to acknowledge the damaging consequences the need or risk may cause, if it remains untreated. As the Police Liaison Officer stated *"...people have got to want help..."*. Throughout the interviews with service providers great emphasis was placed on the autonomy of the sex worker. Autonomy has not always been recognised in the past as an important consideration affecting delivery and provision of health care for sex workers. Service providers believed sex workers have a right to health care services for a need or risk from any cause but specifically from selling sex or problematic drug use. Service providers explained autonomy was enabled by supporting sex workers, for instance if a risky behaviour could not be stopped, attempts were made to minimise risk. As shown by the following quotation of Sexual Health Outreach Worker (B) when talking about drug use,

"...if people are injecting it's being there for injecting users, if they choose to continue to inject try and make sure that they are aware of all the safety stuff around that" (Sexual Health Outreach Worker B).

Service providers emphasised sex workers could not be forced to attend appointments, work in different ways or reduce their drug use because the service provider believed it was in the sex workers' best interest. Use of force was unethical and would further diminish sex workers' rights and power, sex workers had to take some personal responsibility to remain safer from 'pollution'. Service providers,

"...don't force it down their throats because there is no point. We can't force people to do anything" (HIV Advice Worker),

"[i]*deally* [you] *want to get them out of it* [sex work] *if you can but you can't always do that or it isn't always appropriate to try*" (GU Senior Health Adviser),

"...you can lead a horse to water but you can't make it drink it and it is very much unless they want the help it's pointless even doing that" (Police Liaison Officer).

Service providers agreed that a chaotic lifestyle could not be changed overnight. Autonomy was supported by giving sex workers all the relevant information, if necessary over a long period of time, in order for them to make an informed choice on the course of action they wished (if ever) to take. Service providers acknowledged priorities had to be reworked, and if necessary the less damaging need and risk were targeted. This meant however that even if a need, in some cases a severe need were identified by the service provider, it remained untreated. As illustrated by Sexual Health Outreach Worker (B) the infection, damaged mental health and problematic drug use remained untreated due to the lifestyle led and priorities held by the sex workers,

"I can think of several women who have brought problems to us and we've said perhaps you should go and get it checked out and we have made appointment after appointment encouraging these women" (Sexual Health Outreach Worker B).

The narratives illustrate that rights were further diminished, vulnerability increased and sex workers were constructed as a moral and physical 'pollutant' when they entered police custody. The Police Liaison Officer explained how sex workers' health status, *"...if they are contagious with Hep C, if they are contagious with HIV"* was automatically entered onto the

police national computer after being assessed by the police doctor. This action was explained in order to safeguard police officers health when checking sex workers they came into contact with on the streets. Health status was also written next to approximately twenty-five sex workers' named photographs convicted as 'common prostitutes' on a board in the office where the interview took place. One sex worker was identified as having Hepatitis C.

The discursive construct of safety and the definition of need and risk as either a priority for treatment or support combined with the discursive sub-themes of reliability and autonomy outline the contextual environment. Within this, service providers make decisions on who receives health care services, those who do not and if chosen what type of health service they receive. Although service providers individually provide care as a priority of treatment or support influenced by their model of care, when services are combined they provide the treatment and support relevant to the needs and risks of sex workers. The service providers' understanding of sex workers' reliability and autonomy sometimes causes the service provider to prevent access or results in the sex worker limiting access, either reducing safety.

On the surface of medical discourse, control of infection and problematic drug use was influenced by the concept of the sex worker as a 'pollutant' infecting others, but has been reduced in importance in favour of the concept of the sex worker as 'polluted' by others. Service providers now criticise and apportion the former attitude to other service providers creating a barrier to multi-disciplinary treatment and access. This change in importance of the concepts appears to be related to a change in method of delivery, in social terms increasing access. Positive differentiation by service providers was only noticeable within the control of infection; treatment and support of sex workers for their problematic drug use was considered inadequate and damaged mental health ineffectual.

Despite identifying and defining various needs and risks that require either treatment and support, the effect of these constructions are limited due to barriers to health care provision. The following section explores these barriers.

II. BARRIERS TO PROVISION AND DELIVERY

Sex workers described barriers in terms of access, whereas service providers explained barriers within provision and delivery. Barriers were understood as caused by the organisational structure (i.e. processes and protocols) of service providers, the stigma of sex workers' perceived risky behaviour (e.g. selling sex) and the resultant needs affecting the delivery of health care provision.

1. ORGANISATIONAL STRUCTURE

It was apparent from the narratives that the organisational structure of service providers clearly affected their delivery processes and protocols of provision to sex workers. The statutory biomedical services providers, operating within fixed structural boundaries, cited waiting lists caused by staff shortages and methods of referral as having the potential to increase need and risk. The unbounded structure of voluntary organisations was considered to increase access to their provision. These aspects are explored in the following sections.

(i) Waiting Lists

Waiting lists were attached to health care services following a biomedical model of health care. Service providers indicated that health care provision, which involved prolonged, intensive treatments specifically in relation to the Statutory Drugs Project, suffered from the longest waiting lists,

> *"...you can't get a drug service if you want treatment such as access to a script or to a detox bed or whatever for love or money at the moment"* (Sexual Health Outreach Worker B).

Service providers acknowledged waiting lists increased both the need and risk to sex workers, reducing their safety. It was not just one waiting list the Locum Drugs Worker reported sex workers had to go on, but the process involved many stages with various waiting lists. As she explained the length of waiting lists ran over *"...months and months. We've got a waiting list now for people just to be assessed".* Once assessed and discussed in the team meeting, if their needs met the service criteria, sex workers with other drug users were reportedly placed on the waiting list for treatment. This treatment was understood to include substitute medication to enable stabilisation and reduction or if a complex problematic drug use, a second assessment. The waiting list for drug detoxification beds was identified to be between six to twelve months. A complex slow

process which service providers recognise a sex worker with damaged mental health, problematic drug use, working from the street and existing within a chaotic lifestyle struggles to negotiate.

A factor to be considered when discussing waiting lists was neither the Consultant Psychiatrist nor the Locum Drugs Worker mentioned a cut off point at which drugs treatment would cease (i.e. no exit strategy). According to the Consultant Psychiatrist the sex worker would attend the agency as long *"...as harm reduction was being served"* and they were able to follow and maintain the agreed treatment goals and aims while regularly attending the Statutory Drug Project. The Consultant Psychiatrist described how individual progress was reviewed every three months at in-house review meetings. However the Locum Drugs Worker believed individuals could be treated *"indefinitely"* as the following quotation illustrates,

> *"...theoretically people should be reviewed and if they are stuck and not moving and not responding to care or treatment they should be challenged but often this doesn't happen"* (Locum Drugs Worker).

Waiting lists according to the Consultant Psychiatrist reduced the amount of care that could be given to a complex caseload due to the pressure to reduce the waiting list, but also deterred sex workers from referring themselves to the project because delivery was not immediate. The Locum Drugs Worker claimed some drug users had been treated, by different drug workers periodically for over ten years raising the question "*...why are they still here, what's changed?"* The Locum Drugs Worker admitted there were some clients who would *"...jump through hoops"* to obtain a prescription doing nothing else to control or reduce their drug use. The narratives illustrate a subtle challenge to the medical discursive construct of safety as discussed in Chapter One. Although the service providers attempt to keep the sex workers safer from infection and further harm by providing substitute medication and counselling, they do not promote personal responsibility or increase awareness of risk. Sex workers continue to be socially and gender vulnerable. The service provider admitted there was no incentive to reduce drug use, no apparent cut off point to treatment, follow-on support or overall strategy of goals. This in turn delayed and sometimes blocked access to the Statutory Drugs Project for many others, adding to the waiting list. She believed the agency reflected the chaos of the drug user,

> *"I think that sometimes* [the project] *reflects its client group in being chaotic and non-boundaried"* (Locum Drugs Worker).

Service providers noted safety could be increased and treatments ensured when waiting lists were circumvented when sex workers were referred by the criminal justice system or were pregnant. The Statutory Drug Project had the treatment contract with the criminal justice system. The criminal justice orders were cited as prioritising drug-using individuals who were assessed to pose a larger risk to the community than other drug users. Thus sex workers were constructed within the legal and moral discourse discussed in Chapter One, reverting in part to the historical discursive construct of pollution, and drug users being acted upon as though they can 'pollute' and put at risk the health, social and economic well being of the general population. The risk drug users posed to their own health was viewed as a secondary issue. Mental health issues when the client was perceived at risk of harm (e.g. suicide) were reported to quicken the referral process, however, for the Statutory Drug Project it was difficult to prioritise, as they worked,

> *"...with the most severely addicted or the people with the most problems around their addiction"* (Locum Drugs Worker).

In addition to limitations of delivery processes, the service providers complained that waiting lists were due to staff shortages within and methods of referral for health care provision.

(a) Staff Shortages

Service providers' linked waiting lists in part to staff shortages within the biomedical, traditional health care services. The Statutory Drugs Project had a high turnover of staff with constant changes of key workers reported *"...and there is a gap before they are replaced"*. The Locum Drugs worker blamed high staff turnover due to *"burn out"* and career moves. She indicated that some sex workers had five or six different key workers during the length of their treatment. Key workers leaving the project resulted in sex workers being lost in the system, discontinuity, caseloads being closed and,

> *"...people have got momentum working with one key worker only for it to be lost when that key worker has gone"* (Locum Drugs Worker).

According to the Locum Drugs Worker loss of momentum led to clients getting stuck and being very difficult to move forward in their treatment therefore lengthening the waiting list. This she explained resulted in *"...a lot of people out there aren't getting a chance at treatment"*. Injectable diamorphine could only be prescribed by the Consultant Psychiatrist under strict conditions of use, which was perceived to lead to very long waiting lists, rumour and rivalry among the clients. She explained the guidelines as necessary due to the expense of the diamorphine and the moral issues attached to prescribing *"naughty"* drug users a drug that they want and a drug that has to be injected a minimum of three times a day. GPs not willing to take on shared care arrangements, unwilling to work with problematic drug users in their surgeries due to safety issues, a large workload and not having the necessary training to prescribe and monitor substitute medication was linked to increasing the workload and extending the waiting lists of the Statutory Drugs Project. All of which increased the social and gender vulnerability of sex workers as discussed in Chapter One, diminishing their rights and their ability to choose health care.

The GU Health Adviser admitted they were spending more time on D&R than was allocated, it was only part of their job but even with three half days a week demand was described as high. The waiting list was reported to be approximately two months, as due to the intensity of the treatment, only two clients could be seen in one half day. If someone was on the waiting list but was not psychologically coping (e.g. with the affects of rape) she stated she would fit the client in before the allocated appointment time. Therefore the waiting list was to a certain extent flexible although dependent on the assessment of the GU Health Adviser on the level of risk the client was deemed to be to their well-being. The GU Health Adviser reported a long wait for D&R treatment in relation to sexual abuse or rape when the police where involved and there was a forthcoming court case. The wait for treatment was explained as not due to the waiting list at the GU clinic. Mental well being of the victim was understood to be surpassed by the requirements of the court to have vivid, detailed accounts of the abuse or rape. If the victim had treatment before the court case the police believed the rape would be less vivid to them and small details may be forgotten reducing the credibility of the victim. The police have no legal power to prevent D&R treatment, but their opinion that it may negatively affect the case obviously puts pressure on the sex worker to comply and acts as a barrier to their right of access. Thus expanding the discursive construct of safety, rights and power discussed in Chapter One, as legal discourse outweighs medical discourse. The police in not wanting the sex worker to receive immediate treatment are decreasing her mental health safety and increasing her

vulnerability as she is 'advised' when to seek treatment diminishing her right to 'choose' and the power to exercise that 'choice'.

Chronic shortages of staff with the necessary skills to undertake a role in sexual health was identified as a major block to providing health care provision for the Family Planning and Sexual Health Advisory Service. The funding was explained as available for the staff and the posts were developed but medical personnel were scarce. The Family Planning Nurse reported clinics being cancelled when staff were on holiday as *"...there are not enough bodies on the ground"*.

(b) Methods Of Referral

From the analysis it was clear sex workers could directly contact all but one (i.e. Statutory Drugs Unit) of the service providers interviewed whether working within a biomedical or social model of care without a referral from another health care provider. On the surface self-referral facilitated risk reduction keeping sex workers safer, it facilitated their right to 'choose' but was reliant on their power to exercise that 'choice'. Nonetheless, the ability of sex workers to self-refer was explained in some incidences to lead to long waiting lists, therefore was perceived as at odds with control of infection and decreasing risk. For the Statutory Drugs Project the work was described by the Locum Drugs Worker as *"...relentless, piles of referrals every week and no shifts at the end of the caseload"*. The two largest referral methods were identified as self-referral and via GPs although the drug users could also be referred,

> *"...through Social Services, probation, other psychiatrists, other medical departments such as obstetrics, Accident and Emergency, by being arrested, transfer from other parts of the country if the client moves"* (Consultant Psychiatrist).

The open referral system was linked to good practice by the staff who worked at the Statutory Drugs Project. To try and manage the demand and reduce the waiting list, not accepting self-referrals had been discussed. However, this had apparently been resisted as it was thought that it would make the service even less accessible to a client group who the Locum Drugs Worker described *"...as probably the most disadvantaged and scapegoated"*. A group who she claimed many health care service providers were reluctant to work with. Her narrative confirmed the moral discursive construct of stigma as discussed in Chapter One. Sex workers were perceived by many health care service providers as 'other',

undeserving with diminished rights to health care due to selling sex which in turn decreased their ability to be 'safe' from infection and harm.

For some of the service providers, rigidity in the way in which health care services were organised decreased access and therefore safety for sex workers. The scope and effect of delivery protocol boundaries will be discussed in the following section.

(ii) Delivery Protocols And Provision Boundaries

Sex workers were acknowledged as being unable to follow or as having diminished rights and limited power within the traditional biomedical boundaries of delivery protocols defined by health care service providers. Protocol boundaries that were understood to primarily involve the service provider *"...setting the framework for this relationship..."*, a framework within which the service user attended the workplace of the service provider at a specific appointment time. The Sexual Health Outreach Workers, the Locum Drugs Worker and the GU Senior Health Adviser believed the power balance between service provider and sex worker within biomedical provision could be altered for people who *"...struggle from minute to minute, day to day"* (Sexual Health Outreach Worker B). It was considered sex workers should be able to modify some of the framework parameters of care within practical and realistic levels (e.g. care location, flexible appointments). Sexual Health Outreach has modified the relationship framework by removing fixed delivery protocols so that users can access it anytime without appointment and has taken its service to the user's environment (e.g. street, home, parlour). This they explain extends the delivery limits of traditional health care even though sex workers are still difficult to contact. As the GU Senior Health Adviser claimed *"I think there is a certain way of working with people..."*.

Open access clinics (i.e. no appointments or referrals required), such as the GU clinic, were perceived to increase accessibility for sex workers promoting safety and thus reducing risk for sex workers. The GU Senior Health Adviser believed open access clinics gave sex workers the flexibility to turn up at any time during a female only session. Sexual Health Outreach supported this viewpoint,

> *"...some of our clients don't suit turning up for appointments. I know that sounds really naff..."*(Sexual Health Outreach Worker B).

The problem the GU clinic was reportedly facing was an increasing workload. At a few sessions just before the interview the GU Senior Health Adviser explained that high numbers of people attending the clinic had forced them to close early due to safety concerns. The situation was being monitored but her concern in changing to an appointment system was loss of access for sex workers as,

> *"I know* [the sexual health outreach workers] *have enough problems of getting them here with a target of a morning never mind a specific time and some of them have been notorious for not turning up for things like follow up Hep B vaccines and things that we would give them appointments for"* (GU Senior Health Adviser).

The GU Senior Health Adviser also believed an appointment system would result in waiting lists. She reported a waiting list of six weeks in a neighbouring GU clinic that had recently changed to an appointment system. She claimed a few people had travelled from that city as due to *"dire symptoms"* they could not wait that length of time to be seen. It was explained 'Old Port' GU clinic did have appointments for people requiring complex procedures, detailed examinations or vaccinations.

Service providers understood some health care service providers needed to have biomedical protocol boundaries. For instance in relation to the Statutory Drug Project, appointments to see doctors were explained as necessary by the Locum Drugs Worker, as the project had to ensure clients were 'safe' with prescribed medication, which has the potential to kill. The clients have to be monitored and could not always turn up when they liked. An issue for the Locum Drugs Worker was the times of the appointments were inappropriate for sex workers,

> *"...how ridiculous it is for drug services to give appointments any time before about twelve o clock...we don't open at weekends, we don't open in the evenings, we close between one and two o clock"* (Locum Drugs Worker).

She reported when a sex worker did not attend their appointments it had been taken for granted by other staff within the Statutory Drugs Project that the sex worker did not want help or was not committed. When in fact as the Locum Drugs Worker claims,

> *"...because they have been so chaotic they haven't been able to keep appointments and the next time that they manage to scrape the money together for bus fare they get there to find that their case has been closed"* (Locum Drugs Worker).

The Family Planning Nurse preferred an appointment system. She believed appointments enabled workload to be spread over the entire clinic opening times and if the client had given consent they could be notified if and when a clinic was cancelled. However, she claimed if someone turned up for treatment or advice who did not have an appointment they would not be turned away although they might have a long wait,

> *"[w]e may be fully booked with patients and appointments* [but] *if we can physically fit them in we will"* (Family Planning Nurse).

The Family Planning Nurse claimed the service did not have a waiting list. The service provider attributed the absence of a waiting list to the fact the appointments were not for a specific need or risk nor were they to see a specific person. The appointment was explained to be with the clinic. The client would see a nurse and if appropriate would be linked with a doctor or be referred elsewhere (i.e. the GU clinic). This inflexible delivery protocol may result in no treatment, just another appointment to see a different medical professional, which is unsuitable for sex workers requiring immediate treatment or support.

Boundaries were not only constructed within the framework between health care service providers and sex workers but between different health care providers. Provision boundaries were believed to limit the type of treatment or support a health care service provided. Sexual Health Outreach Worker (A) explained opportunities to educate and treat sex workers were being missed, due to the provision boundaries of biomedical health care service providers. As it was difficult to get sex workers to attend appointments, she maintained more use had to be made while sex workers were at appointments as they were then a *"captive audience"*. As such she believed GU clinics,

> *"...should encompass cervical screening, it should talk about contraception, or should talk about problem periods it should talk about everything not separate things..."* (Sexual Health Outreach Worker A).

This unbounded type of health care provision was constructed as important, as prostitution was only part of the sex worker's identity - she was also a partner and possibly a mother. Service providers explained health care services needed to put treatment or support into the context of the sex workers' whole life and not just their work life. Sexual Health Outreach Worker (A) believed health care services needed to work more closely and more creatively, more focused and directed to improve delivery and thus access to provision. Her

narrative illustrated a need to construct sex workers outside of the negativity within medical, moral and legal discourses as discussed in Chapter One, thereby increasing the safety, rights and power of the sex worker and decreasing the stigma attached to sex work. Improvement was understood to require the sharing of processes and ideas of service providers from both models of care and both sides of the sector. As illustrated, the improvement included the Sexual Health Outreach Project as when asked to list the agencies she liased with her reply was *"[w]ell we don't have... I wouldn't say we have a huge liaison".*

The Sexual Health Outreach Project reported neither waiting lists nor staff shortages, sex workers could self refer to the project, it was based on 'outreach' principles and it was understood at times to be sex worker led. Nonetheless there were acknowledged important barriers to providing treatment or support for sexual health and control of infection. One barrier identified was the location of the Sexual Health Outreach Project, based in a drug and alcohol agency. This location was identified as facilitating referrals and networking for reducing drug use and increasing safety. However, although Sexual Health Outreach Worker (A) claimed problematic drug use was both a need and risk for sex workers so location was *"...very relevant to a lot of our clients...".* She believed due to the project's location sexual health was not a priority. An additional disadvantage discussed was the inability to organise focused group sessions on sexual health, a fact that had not gone unnoticed by other service providers. For instance the HIV Advice Worker was aware that one of the Sexual Health Outreach Workers had,

> *"...always wanted to do some real, in-depth work with them and I think it's just such a shame that that's not happened"* (HIV Advice Worker).

Although changes were identified as necessary to organisational structures, delivery protocols and provision boundaries, it was stated that barriers to access would still exist due to the stigmatising attitudes of service providers and the sex workers' perception of stigma associated with their needs, risks, provision and access. The following section examines these issues in detail.

2. STIGMA

It was taken for granted by the service providers that the moral discursive construct of stigma as discussed in Chapter One was attached to both sex work and problematic drug

use. As Sexual Health Outreach Worker (B) states *"...I think there is the obvious...the old stigma again"*. The discursive construct of stigma within moral, medical and legal discourses dominated the interview narrative. Stigma was interconnected with the discursive construct of 'pollution', specifically the 'polluted family' and 'polluted womanhood' encompassing infection and immorality. Stigma was perceived to be evident within the personal biases of other service providers. The Locum Drugs Worker when discussing the attitudes of other service providers towards drug using sex workers reported, *"...its like how can anybody sleep with men to buy drugs, why don't they just stop"*, she believed this indicated how their lack of understanding of the sex workers lifestyle could lead to stigmatising behaviour. The Senior Drugs Adviser identified some of the psychiatric nursing staff having negative attitudes to people with problematic drug use admitted to the detoxification beds on the psychiatric ward who perceive,

> *"...drugs are a stigma, mental health* [damage] *is something that happens to someone whereas drugs and alcohol are self-induced, they* [psychiatric nursing staff] *don't see it as an illness"* (Senior Drugs Adviser).

It became evident that the perceived extent of stigma and the main risk behaviour it was attached to, sex work or problematic drug use was dependent on the remit, speciality and experience of the service provider. Some service providers' narratives confirmed the moral discursive construct of stigma while others resisted it. Whether sex workers were constructed as stigmatised for selling sex, taking drugs or both, stigma limited access to health care provision. Service provider staff attitudes to sex worker care are illustrated by the following quotations;

> *"...not getting access to care...that they've had a really poor experience....which I think can be a big deterrent to them wanting to return to care and medicine"* (Sexual Health Outreach Worker B),

> *"...mention the word drug, mention the word cannabis and that's drug service regardless of the circumstances"* (Locum Drugs Worker),

> *"...if you are a drugs user and a sex worker all the odds are stacked against you, it's very difficult to go somewhere if you think you are going to be judged..."* (Sexual Health Outreach Worker A).

For the majority of service providers stigma attached to prostitution was identified as the most obvious reason for sex workers not to access health care that would keep them 'safe' and reduce risk. For the GU Senior Health Adviser, stigma attached to sex workers by other service providers limited provision,

> *"[i]f it is known that they* [sex workers] *are working unfortunately amongst the medical profession 'oh a prostitute' and they may not generally be looked at in the same way as anyone who hasn't committed it* [prostitution]" (GU Health Adviser).

Service providers' stated aim was for sex workers to reduce their risks, be 'safe' which would be achieved by stopping sex work. This was perceived as being blocked for many reasons among which was the stigma attached to sex work, resulting in negative attitudes that prevented alternative exit opportunities. Stigma of being constructed as a moral and physical 'pollutant' as discussed in Chapter One was understood to stop many sex workers signing on for benefits. Benefits that it was claimed enabled them to stop selling sex or at the very least reduce the hours they needed to work and therefore reduce the risk to their health. Sexual Health Outreach Workers (B) recalled accompanying a sex worker who had been badly beaten while working to the Social Security Offices. The sex worker was claiming benefit, as she could not work due to her injuries. The Sexual Health Outreach Worker believed sex workers could not cope with being asked how they had previously been supporting themselves without the benefits. The way around these questions was explained to be on the advice of a welfare rights organisation, which suggested sex workers claim a partner has been supporting them but to leave it as vague as possible.

Interestingly stigma attached to either the service provider or location of the health care service was identified by some service providers as limiting or preventing access to health care services. Stigma was understood to be attached to the service provider not the sex worker thus extending the moral discursive construct as discussed in Chapter One. It was how both sex workers and service providers identified other service providers and the way service providers were seen to deliver their service, for instance treating problematic drug use or general advice, showing understanding or being judgemental. The Family Planning Nurse discussed that in the hope of moving the service away from the stigma of being known as the *"...twin set and pearl brigade..."*, Sexual Health Advisory Service had been added to the title and the white uniforms had been replaced by everyday *"normal"* clothes. It was perceived the changes would remove the idea of the Family Planning service as staffed by middle aged, middle-class women who had very traditional attitudes about sex

and the family. Out dated ideas and practice that before the changes the Family Planning Nurse believed sex workers thought would lead to discriminatory practice. Her narrative suggests partial conformity by 'other' staff with the moral discursive construct of sex worker as 'pollutant' with diminished rights to health care as discussed in Chapter One. Additionally stigma being attached to the actual health care service results in self-blocking by the sex workers, leading to further stigmatisation as service providers have little contact with sex workers. Both sex worker and service provider become stigmatised. The Family Planning Nurse indicated the changes had not been entirely successful,

> *"...a lot of people still see us as Family Planning which is unfortunate really because it is not meant to be like that because we are supposed to do a lot more holistic approach to care"* (Family Planning Nurse).

Stigma attached to health care services was explained as also reducing referrals between services. The narrative illustrates the legal discursive constructions of rights (i.e. the right to 'choose') and power (i.e. the ability to exercise that 'choice') as outlined in Chapter One. In this instance both were diminished, as the sex worker was not given the opportunity to choose the health care service to attend. Control of infection was made more difficult, increasing vulnerability and the risk of damage within their lifestyles. The GU Senior Health Adviser identified Family Planning as *'[t]he only thing that we don't have close links with..."*. Sexual Health Outreach Worker (B) believed the Family Planning and Sexual Health Advisory Service had,

> *"...never connected well with our women and a lot of our women have said that their experience with Family Planning hasn't been brilliant in the past"* (Sexual Health Outreach Worker B).

She identified within Family Planning and Sexual Health Advisory Service few significant changes and described it as *"...no more valid for women"*. Interestingly the Family Planning Nurse seemed unaware of the continuing stigma attached to the service by other service providers. The Family Planning Nurse assumed, as the Sexual Health Outreach Workers knew about the service they were,

> *"...able to talk to the women about the service and be able to facilitate their access to it if they want...*.[the Sexual Health Outreach Workers] *are my links with the working women population"* (Family Planning Nurse).

Stigma is associated to sex work and problematic drug use and is increased when there is evidence of infection. Infection is only a fear until confirmed by blood tests. On admission to the detoxification beds, it was reported drug using sex workers were encouraged to have blood tests for HIV and Hepatitis. The Senior Drugs Adviser explained the emphasis was on the sex worker making the first move but if they initiated the test one wonders why they need to be 'encouraged'. The HIV Advice Worker maintained people were *"pushed"* into having blood tests and explained they had to be at the right stage of their lives to have the test and deal with the consequences (e.g. increased stigma) if positive. She believed that many people were not prepared to receive the news that they have a potentially fatal disease.

> *"We have to pick up the pieces because they think "I'm going to die" and then they go out and use more and the next time you hear of them they're in* [psychiatric care] *or in custody"* (HIV Advice Worker).

Service providers realised there were organisational barriers within the delivery protocol due to waiting lists, staff shortages and the methods of referral, and provision boundaries due to remit and speciality that affected sex workers accessing, and thus safety. Service providers understood that the stigma of services, sex work, problematic drug use and infection further reduced the access for sex workers. These forms of stigma appeared to be accepted by the service provider with little change apparent in their construction.

III. CONCLUSION

This chapter has illustrated service providers' construction of provision and delivery of services for sex workers was not only based on their understanding of sex workers' need and risk but also on a number of factors relating to the service and the sex workers lifestyle. A major factor affecting service providers' construction was the perception of sex workers' reliability. Treatment was often considered to be unsuccessful because sex workers could not keep to treatment programmes or attend appointments due to unpredictable behaviours, often a result of problematic drug use and damaged mental health. Due to this, service providers either gave sex workers a large amount of leeway in access provision or it reduced their willingness to allow access, concerned about wasted resources and opportunities. Autonomy was associated with reliability, the service providers understood

they could not force sex workers to attend and have treatment, but they could support them during the treatment and increase their knowledge of risk reduction, therefore reducing need. It was realised that until the sex worker reached a turning point in her life when care was actively sought, treatment and support would remain prioritised by sex workers as maintenance and prevention rather than corrective care.

Stereotypes of the sex worker as a drug user were evident in affecting the construction. Problematic drug use was considered a major problem attributing to the chaotic lifestyle, working patterns and, as indicated, reliability. This resulted in service providers focusing on this problem all of which had to be negotiated with the sex worker although treatment was considered to have little success. Sex workers were perceived in need and at risk of damaged mental health, vulnerable, often suffering from PTSS and were often unable to cope with reality or change without the support of drugs, which service providers believed made treatment difficult (e.g. D&R).

Biomedical care provision and delivery remain strongly influenced by the medical institutional power groups, but some movement had occurred within delivery from social relational contacts with sex workers and social service providers. Major factors specific to the service provider that affected their construction were delivery and provision barriers. Biomedical service providers' traditional access protocols were perceived as too rigid and problematic for sex workers, although access protocols were necessary due to the treatments provided and demand and resource limitations. Barriers were understood as waiting lists made worse by staff shortages, self-referral, inflexible opening times, providers who were unwilling to share care or work with drug users and sex workers. The lack of holistic care was perceived as a problem. Social service providers believed they had the time and flexibility to create trusting relationships with sex workers in which they were non-judgemental, committed, impartial and could empathise with their issues, providing social support (e.g. literacy, housing, finance) to reduce risks and act as advocate to other services.

Stigma was associated with other service providers because of professional ideologies and personal bias, often because of a lack of interaction with and understanding of sex workers lifestyles. It was also understood the atmosphere was not conducive to honesty not enabling the admission of unsafe sex and drug practices for fear of further stigma. Service providers perceived as a whole they were struggling to provide care to sex workers under

increased workloads from self-referrals. Attendance levels were too high and treatment success rates reduced. They lost continuity due to long waiting lists and resource was wasted due to missed appointments. A lack of an exit strategy for problematic drug use was an issue with no current solution.

Within the discursive construct of pollution, there has been a change in perception. The majority of service providers now view the sex worker to be 'polluted' by the client and this has positively affected attitudes, improving the delivery of provision. Nonetheless some service providers are still believed to ascribe to the belief that sex workers are a 'polluter of others' in relation to sexual health and problematic drug use. These moral and medical beliefs continue to stigmatise, reducing access.

Barriers in all their forms are seen within the discursive construct of rights to reduce sex workers' rights of access. Within mental health provision, ineffectual and inappropriate provision negates their right to correct effectual treatment. Service providers understand that problematic drug use and damaged mental health reduce the sex workers' power to access care, and work towards reducing risks and increasing autonomy. Service providers following a social model of care (e.g. SHOP) can via support empower sex workers, albeit slightly, to increase access and thus their rights to provision.

This chapter has fulfilled the fourth objective of the study. The study aim can now be considered in the following chapter based on the knowledge gained from the four objectives.

Chapter 8

OBSERVATIONS AND CONCLUSIONS

This study illustrates the constructions of need and risk are complex and different, thus not easily quantifiable. The discursive constructs are intrinsically linked to tensions and contradictions affecting both sex workers' and service providers' understandings. Contradictions in constructions that arise specifically from the sex workers chaotic lifestyle (e.g. problematic drug use, damaged mental health, the necessity to work) and the service providers, who define need and risk in biomedical health terms based on experience and medical knowledge. Access to and provision of health care services is constructed primarily within the discursive constructs of safety, stigma and pollution with aspects of rights and power, by both sex workers and service providers. This chapter sets out the conclusions to the thesis and reiterates the basic argument. In doing so, it is broken into two sections that separately address the thesis; to understand the (i) differential construction of need and risk and the (ii) differential construction of access and provision. The chapter simultaneously offers an explanation for the continuation of need when health care provision exists, and possible implications of the research findings for sociological theory and social policy practice.

I. THE THESIS AIM AND STUDY OBJECTIVES

This thesis had one main aim, which was supported by four objectives. The main aim identified and examined the differential understandings of need, risk, access and provision between sex workers and health care service providers in the context of prostitution. To understand the differential constructions the following objectives were fulfilled: the identification of *discursive themes,* how they were constructed by a *specific interviewee* and directed by underlying influences;

(i) need and risk, by the sex worker (see Chapter Four)

(ii) need and risk, by the service provider (see Chapter Five)

(iii) access and provision, by the sex worker (see Chapter Six)

(iv) provision and delivery, by the service (see Chapter Seven)

The differential construction based on these objectives is explained in the following section.

1. THE DIFFERENTIAL CONSTRUCTION OF NEED AND RISK

The stigmatising and disempowering mental health needs and physical health needs, primarily caused by drug addiction, prevented sex workers from coping with social (e.g. bringing up children), medical (e.g. health care appointments), economic (e.g. bills, benefits) and environmental situations (e.g. housing, lifestyle). Construction of need and risk was made within this socially specific context of prostitution in 'Old Port'. Sex workers' knowledge of health need and risk was based on their personal and peer experiences (e.g. of infection, violence, damaged mental health), service provider advice and contact, drug use (e.g. drug addiction, sharing needles, exchanging sex for drugs) and street prostitution (e.g. unsafe sex, desperation, STIs). Sex workers understood health issues as either problems or needs. The sex worker used health care knowledge to determine when a problem became a need based on her level of ability to function (e.g. necessity to work, reduced ability to work, need of medication, problem is continual and long term, some form of intervention is required), the conditions (e.g. in withdrawal), rules (e.g. use of condoms) and authorities (e.g. important others) when experiencing the health problem.

The distinction made by sex workers between need and risk was a temporal one. Need, even though long term and for some sex workers a need since childhood, was a present need (i.e. past and future needs were ignored), whereas risks to health were based on what had happened in the past and could happen based on their activities (e.g. prostitution) in the present. Thus for sex workers risk implied context. However, service providers made no clear temporal distinction between need and risk, indeed they were identified as the same. For instance service providers identified STIs as a past, present and future need and risk, and as such varying levels of provision were made available.

Sex workers' construction of need and risk was primarily dependent on the ways in which they understood the 'right' and 'wrong' way to work. Sex workers categorised behaviours as either responsible (e.g. safer sex, safer injecting practice, not using drugs) or irresponsible (e.g. sex without a condom, using and sharing needles, working while under the influence of habit-forming drugs). Their needs (e.g. problematic drug use, damaged mental health) affected their choice of work location (e.g. street), which in turn increased the risks to their

health (e.g. violence). Sex workers working privately identified a clear divide between their responsible behaviour and the perceived irresponsible behaviour of the majority of sex workers working from the street. On the streets the distinction between responsible and irresponsible behaviour centred on drug use, specifically on the use of needles. Thus responsible behaviour had a different emphasis depending on the location of work and created a hierarchical structure within prostitution, a relational structure affecting behaviour, status and the allocation of blame.

Service providers constructed need and risk based on biomedical knowledge expressed within professional ideologies, staff training and experience. Biomedical principles were the primary factors for service providers working within problematic drug use, sexual and mental health care provision. Service providers used social model of care attributes (e.g. empathy, negotiation) to varying degrees to aid in their understanding of sex workers' lives, thus helping them build a trusting relationship with the sex worker to enable effective care. This relationship was the primary factor for sexual health care via the Sexual Health Outreach Project. The service provider understands the sex worker's lifestyle as containing certain characteristics which relate to the understanding of need and risk and the extent of both; the first being that of desperation, desperate to escape poverty and prostituting to survive, putting sex workers at risk of damaged mental health, STIs and violence. Desperation was also associated with problematic drug use, the desperation to prevent withdrawal thus prostituting to earn money for drugs. Sex workers were also considered to be victims of previous abuse and current violence, increasing their vulnerability, affecting their physical and psychological health. A few of the service providers categorised sex workers as either 'amateur' or 'professional' depending on the sex worker's working pattern, experience and problematic drug use. The 'amateur' was considered to be unaware of or not understand the risks involved in prostitution and therefore at greater risk. The service providers' understanding of the type and level of need and risk was dependent on the classification of the sex worker as either the 'same as' or 'different from' non-sex workers. There were however conflicting opinions when comparing STIs, problematic drug use and damaged mental health; some service providers constructed sex workers as the same as non-sex workers, others as different.

The sex workers construction concerning STIs is based on the sexual exchange and drug addiction behaviours related to responsible (i.e. 'normal' STIs) and irresponsible behaviour (i.e. 'abnormal' STIs). Sex workers construct an attitude that thrush and cystitis are 'normal'

STIs as they are acceptable common sexual health needs, which can result from unpaid sexual intercourse between non-sex workers and their partners. Thus 'normal' STIs are identified as a need without fear of stigma or blame. 'Abnormal' STIs (e.g. syphilis, gonorrhoea, HIV/AIDS) are understood as a risk. The service provider is unaware of this categorisation, identifying all possible STIs as needs and risks. STIs appear to be an understood, accepted and managed need of lower priority to both sex workers and service providers.

When risks are compared sex workers do not identify problematic drug use and damaged mental health as risks because they are constructed as constant day-to-day needs. For sex workers the need priority is primarily problematic drug use; service providers agree but they also identify damaged mental health as of equal priority. The construction of damaged mental health and problematic drug use as needs was based upon the inter-relationship with prostitution. Many sex workers indicated that prostitution compounded their existing mental health damage (e.g. low self-worth, low emotional strength). Therefore mental health needs were made worse by prostitution but were not solely a result of it.

The analysis emphasises sex workers do not identify violence as a need. The sex workers constructed violence as a risk because it allowed them to have the courage to work, it was a one-off event (i.e. not a constant need) and was perceived as causing limited damage to long-term health. Sex workers downplayed violence as a risk identifying it in the context of happening to 'other' sex workers and a risk they themselves should be able to prevent by following responsible behaviours. If a sex worker was attacked she blamed herself and if other sex workers were attacked their behaviour was blamed. Violence was not constructed as the fault of the perpetrator. When the violence involved sexual assault (e.g. rape) the sex workers identified an increased risk of STIs, especially 'abnormal' STIs. For the service provider risk generally implied prevention. Violence was the exception, constructed in terms of its effect (e.g. broken bones, cuts, bruises), as this is what they could treat but could not prevent. Sex workers understood violence in terms of the cause (e.g. stealing, irresponsible behaviour), which they could attempt to mitigate against.

Despite constructing temporal distinctions between need and risk, and the complexity of need, sex workers had developed an extensive set of strategies to self-medicate a need or reduce a risk. Not all strategies were without additional risks (e.g. self-harming to reduce feelings of self-hatred) and some sex workers were more able to use them than others.

Need reduction strategies were wide ranging, encompassing the use of non-prescription drugs to medicate damaged mental health, or a make-over, changing work location and the conception of the client as 'sad' (i.e. pathetic). Sex workers believed these strategies enabled them to medicate against anxiety, low self-worth, lack of control, guilt and shame. Risk reduction strategies were more extensive and related to responsible behaviours particularly in relation to sexual (e.g. self and client cleanliness, safer sex, only going with right type of client) and drug abuse behaviours (e.g. non-injectable, non-addictive, if injecting using clean needles and a Sharps bin). Compartmentalisation, denying specific sexual acts and using a range of mental concepts (e.g. being important, selling their time and not their body) were strategies providing additional sexual detachment, believed to mitigate physical and verbal abuse, low self-worth and stigma. It is quite remarkable that the sex workers have built up such an extensive set of strategies and acceptable levels of behaviour to allow themselves to continue within their dangerous lifestyles only dipping into health care when absolutely required or capable.

To summarise, sex workers and service providers use different 'rules' to determine need and risk. Sex workers' construction of need and risk is dominated by occupational health considerations (e.g. the right and wrong way to work) and the necessity to work. These direct the distinction between problem and need, need and risk and are influenced by the inter-relationships between prostitution, damaged mental health and drug addiction (e.g. damaged mental health compounded by prostitution). The distinction between health need and health risk for the sex workers appears to be a temporal one, need is present whereas risk to health is based on the past and on the future. The majority of service providers define need and risk based on experience, knowledge, training and professional ideologies within the biomedical model of care. Their construction is limited by the remit and speciality of the health care service. Some service providers exhibit attributes of the social care model to create trusting relationships. Some perceive sex workers as the same as non-sex workers, others as different, resulting in different priorities attached to need and risk. Sex workers and service providers identify need and risk as problematic drug use, damaged mental health, STIs and violence, but categorise and prioritise differently.

2. THE DIFFERENTIAL CONSTRUCTION OF ACCESS AND PROVISION

The type of health care provision accessed by sex workers was dependent on work location (i.e. privately or from the street), the category and method of drug usage while working (e.g. habit forming, intravenous) and their life history (e.g. sexual abuse, previous

experience of statutory or voluntary services, damaged mental health). Health care was understood as either work or non-work related. Service providers influenced by their model of care individually provide care as a priority of treatment or support, to reduce risk and therefore keep the sex worker 'safe'. The Sexual Health Outreach Project made available and delivered preventative equipment and gave advice to those working from the street but the majority of service providers would or could not provide outreach due to fixed biomedical protocols. For all of the street sex workers interviewed, access to preventative provision was increased due to the sexual health outreach workers compared to many of the sex workers in parlours, within which outreach access was denied.

Service providers act as 'important others' (e.g. boyfriends, husbands, friends) by directly blocking access as a result of personal bias or resource limitations, and indirectly due to the complexity of access within the biomedical organisational structure. Many sex workers due to problematic drug use were unable to prioritise their health and access health care services for either treatment or preventative care. Service providers recognised problematic drug abuse negatively affected sex workers' reliability in attendance and willingness to following treatment programmes. Sex workers' autonomy described as lacking in many of the lives of the sex workers, prevented service providers enforcing treatment. Autonomy when combined with the sex workers' unreliability caused by problematic drug use and damaged mental health, resulted in the occasional blocking and therefore unavailability of a health care service (e.g. either intended blocking by the service provider or unintended self blocking due to the sex workers' behaviour). Unavailability of treatment leads to the continuation of or increased problematic drug use, which increases the risk of mental health damage, in turn intensifying their erratic unpredictable behaviour. Thus a further damage relationship is identified. Service providers following a social model of care were more accommodating and supporting of unpredictable behaviour when compared with traditional biomedical service providers who were limited due to rigidity of the organisational structure (i.e. processes and protocols) and the medical priority as corrective treatment. Delivery protocol barriers made access problematic for sex workers. This is a primary factor in the construction of delivery and provision of health care dealing with problematic drug use, sexual and mental health.

Due to the sex workers' autonomy and chaotic lifestyles, service providers accepted the treatment priorities of sex workers had to be addressed first before the treatment priorities of the service provider would be considered. Priorities had to be reworked. The priorities of

the sex worker were generally occupational health priorities and short term. So although for the service provider provision implied treatment or support they accepted provision as being initially one of risk reduction (i.e. keeping the sex worker 'safe' from infection, violence), maintenance and stabilisation until the sex worker experienced a life event causing a change in their perspective when corrective treatment was sought. When treatment was sought by the sex worker the type and level of care delivered was related by the service provider to the level of risk the sex worker was exposed to and the capability, dependent on problematic drug use and damaged mental health, of the sex worker to understand and follow treatment. These are primary factors affecting the delivery of care for all needs and risks. For instance the service provider considered a range of sex worker drug abuse factors (e.g. method of intake, method of finance, the periodicity, the amount, the type, duration, motivation to stop) to determine the type of care required (e.g. stabilisation, detoxification or rehabilitation) and the level of medication (e.g. dosage of substitute medication).

The sex workers choice of health care provision and when to access it was not solely based on need or risk but was underpinned by the discursive constructs of safety, stigma and pollution interconnected with drug use, mental health and sexual health. Sex workers prioritised their needs and risks based on occupational safety, which therefore affected the choice of health care (e.g. a sex worker addicted to drugs would prioritise substitute medication over sexual or mental health care to be 'safe' from withdrawal). Of equal importance was the need for sex workers to feel 'safe' within the contact with the service provider. Sex workers needed to know that they could trust the service provider to be non-judgemental, allow anonymous access and provide an effective and competent service. For the sex worker the relationship with the provider was 'all important' in determining whether to access health care services. Stigma affected the choice, as sex workers would not access services where they felt stigmatised either by the provider or other service users. The construct of pollution was very much intertwined with safety and stigma. Sex workers did not perceive themselves as 'polluters' and would not be stigmatised by the association, thus service providers who had this opinion would not be accessed.

Service providers identified, criticised and apportioned the concept of the sex worker as a 'pollutant' to 'other' staff working within traditional biomedical health care services, creating a barrier to multi-disciplinary treatment and access. Service providers working within or partly following a social model of care (e.g. SHOP, GU) acknowledged using positive

differentiation (e.g. fast tracking, prioritisation) due to their understanding of sex workers lifestyle. Good training and in-depth experience were identified as important factors affecting the delivery of health care. However, some service providers reported mental health services were failing to meet acceptable levels of care. Service providers obviously stated the remit and speciality of health care services affected the kind of service provided and the extent of the service delivery, (e.g. GU D&R was restricted to women with sexual health problems). Service providers limit their construction of need and risk accordingly, thus representing a primary factor in defining the health care service. The services are evolving albeit slowly resulting in the service providers identifying a number of operational issues that are negatively affecting delivery of the service provision. These issues affected their construction of delivery at the time of the interviews. For instance open access for the GU clinic increased the workload as attendance was too high, resulting in clinics closing, and self-referral for drug substitution extended already long waiting lists. Limited resources affected delivery, specifically of health care services treating problematic drug use and damaged mental health. Biomedical service providers understood access in terms of delivery of treatment.

To sum up, sex workers and service providers use different criteria to access provision and deliver care. The sex workers' access is dependent on their perception of stigma within the relationship with the provider, blocking by self and important others, and short term health priorities within occupational safety. The majority of service providers deliver care aimed at keeping the sex worker safer, some service providers deliver care to prevent the sex worker from being 'polluted' or 'polluting' others. Health care is generally based on the rigidity of the biomedical model limited by the autonomy and reliability of the sex worker, remit and speciality of the health care service, service provider personal bias and resource limitations. Barriers in all their forms are seen within the discursive construct of rights to reduce sex workers' rights of access. Service providers understand problematic drug use and damaged mental health reduce the sex workers power to access care, and work towards reducing risks and increasing autonomy. Service providers operating within a social model of care have extended the boundaries of access and delivery by the use of flexible protocols and positive differentiation. Treatment priorities are dictated by the sex worker due to their occupational emphasis within their chaotic lifestyle primarily caused by problematic drug use and damaged mental health.

3. THE CONTINUATION OF NEED

The differential understandings of need, risk, access and provision and at times rigid, uncoordinated health care provision contribute to the continuation of need. Health care is primarily influenced by the traditional biomedical model within which need and risk are formally identified, constructed and clearly defined. Health care provision therefore only addresses specific rather than holistic needs (e.g. a patient attends GU with a STI, the aim is to stop the infection). However, this straightforward treatment plan becomes more complex when the patient is a sex worker; has sex with many clients, problematic drug use causing unpredictable behaviour, a limited understanding and reduced capacity to retain information due to damaged mental health, but desperately needs to work (i.e. solicit). Therefore, the extent of the majority of sex workers' needs and risks are extensive and intertwined with no clear, quick, specific treatment solution. Mental health needs, problematic drug use and prostitution are multiply inter-related to such an extent, that when the sex worker attempts to address one of the issues (e.g. drug addiction within a specific health provision such as substitute medication), there can be little hope of success, as the other issues remain (e.g. prostitution, damaged mental health) which can reactivate the treated issue. Even when all three aspects are addressed together, the sex worker is still at risk of the damage restarting, as often the environmental, financial and social circumstances remain the same. So although health care provision exists, it often requires levels of commitment and reliability that are not possible from a sex-worker alone, with complex hurdles of access (e.g. GP referral, waiting lists, appointments). Sex workers can very quickly be placed at the 'bottom of the pile' as health care providers cannot cope with the multifaceted needs and risks that sex workers present, and as such when they are treated health care services only touch the surface. Health care becomes purely maintenance of the sex worker who is caught within a complexity of social, economic and welfare relationships.

In addition and partly due to the complexity of need and risk, the sex worker is only interested in and can only cope with accessing provision for present needs, and sometimes even this is not possible. For the sex worker access implies immediacy of provision. There can be little or no forward planning. Identification of need and risk is a selective process dependent on their ability to work. Service providers particularly within the biomedical model of disease do not have a temporal distinction between need and risk (e.g. a health need requires treatment due to the future risk it poses). Due to traditional organisational structures the service providers do not have the processes and access or delivery protocols to deal with immediacy (e.g. waiting lists need to be negotiated, appointments have to be

made). Autonomy and unreliability complicate the biomedical access process by further blocking access therefore increasing need.

4. IMPLICATIONS OF THE FINDINGS

This section discusses the possible implications of the research findings for sociological theory and social policy practice.

(i) Theoretical Implications

This research not only identifies the need and risk as described by sex workers and service providers but investigates the way in which need, risk, access and provision of health care is constructed and understood by the two different populations (i.e. sex worker and service provider) and sub sections within those populations (i.e. sex worker working from the street as opposed to sex worker working in a parlour). In interviewing both sex workers and service providers, greater consideration and awareness of provider and receiver relationships and perceptions is gained and differential constructions are understood. In conjunction the research provides an insight into the processes and influences that direct the construction. The research expands our understanding of violence specifically the differing constructions of violence and develops the debate of the sex workers construction of identity and self with respect to the implications of separation of work and non-work, and prostitution as work, control and belonging. The definition of the theoretical and analytical frameworks adds to the methodological debate. The analytical framework provides a greater emphasis on an integrated methodological approach than has occurred in previous research. In addition utilising diagrammatical representations to bring together the multitude of discursive constructs, themes and discourses to relate research themes to published discourses.

(ii) Practice Implications

The thesis explores the relationship between sex workers' understanding of need and risk and their use of health care services that are important to service providers' policy and practice initiatives. An important finding of this research is that independent health care provision fails to sufficiently address the needs and risks of the sex worker. As has been clearly identified in this research the sex worker cannot always negotiate access within the fixed biomedical protocols. The Sexual Health Outreach Project provides possible answers for service provider's policy and practice initiatives. The SHOWs exist within the domain of the sex worker and have the knowledge and understanding of sex workers' lifestyles and

limitations, and can operate within the protocols of the health care system to facilitate negotiation and act as advocate on the sex workers behalf. However, the SHOWs as the title suggest are currently heavily associated with sexual health and additionally problematic drug use by sex workers, limiting the SHOWs effectiveness. SHOWs need to evolve so that outreach workers working with sex workers support sex workers so they can receive holistic care (i.e. not just addressing one health issue alone e.g. sexual health) whilst consideration is given to the social care aspects, on a one to one basis. Outreach workers need to ensure they are not solely associated with, while still providing advice and information on, sexual health and safer drug use. This allows the existing individual systems of biomedical access and provision to exist, but provides a health support worker who is trusted by the sex worker and can negotiate and support access for all their needs and risk, supporting attendance and advising on provision. This would not only provide greater flexibility but a more open environment for discussion. To bridge the limitations of the outreach workers other specialities (i.e. GU, Family Planning, housing, Citizens Advice, mental health) need to be made available (e.g. once a fortnight) on a drop in, flexible basis at an Outreach Project. The same service providers from the specialities need to attend each session to ensure continuity of care, rapport and trust. Co-operation and liaison between health care services needs to be continued and built upon so enabling fast tracking of sex workers into services, particularly drug services and mental health. Mental health is a serious health need, the severe short fallings in psychiatric health care provision not only need to be recognised but also responded to. Sex workers require one to one treatment support programmes which relate to the sex workers lifestyles, with clear entry and exit criteria allowing targeted combined treatment programmes (e.g. D&R with psychiatric support and drug therapy).

To conclude, need and risk continue, the complexity of which cannot be addressed by existing uncoordinated biomedical care with inflexible protocols and provision boundaries. Contradictions and tensions exist within the differential construction of need, risk, access and provision, made more problematic by the chaotic lifestyle of many sex workers. Account needs to be taken of the sex worker's socio-economic conditions, which influence her involvement within, construction of, and choices made, in relation to prostitution. The differential understandings must be recognised in an environment of increasing numbers of sexual and drug outreach projects or more punitive measures will be imposed via the criminal justice system and the sex worker will continue to be 'maintained' within a damaging lifestyle.

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GLOSSARY

ACCESS	Discursive theme – the right or opportunity to use health care *e.g.* - *improved access due to SHOP extending care onto the streets* - *blocked by SW chaotic lifestyle* - *blocked by SP lack of resources*
ANALYTICAL FRAMEWORK	A set of methods and theories that will be used to perform the analysis - *Foucault discourse analysis* - *Bradshaws 'Felt Need Theory'*
AUTHORITY	Power/influence to cause/force another individual to act because of recognised knowledge/expertise/fear *e.g. Doctor, police, parlour owner, pimp, partner*
BEHAVIOURS	How individuals act or react to events, perceived cultural norms/moral code that are expected in how they conduct themselves. *e.g.* *- Responsible behaviour = moral code* *- Damaged mental health -> self medicate with problematic drugs to block destructive feelings* *- Compartmentalisation to protect mental health and against stigma*
CONDITIONS	Circumstances or states that influence or affects the individual *e.g. Problematic drug use, poverty*
CONSTRUCTION	The rules that an individual follows under certain conditions limited by specific authorities. The rules are directed by the cultural relationships, their interpretation and meanings of social events and their behaviours. *e.g.* - *SW construction of need and risk* - *SW construction of access and provision* - *SP construction of need and risk* - *SP construction of access and provision*
CONTRADICTIONS	inconsistent statements/opinions or behaviours that oppose each other e.g. *- use of condoms with clients/non use with partners* *- distancing themselves from infection but use of 'prostitute as infected' to protect against unprotected sex* *- drugs to help work but drugs increase risk*
COYOTE	Call Off Your Tired Ethics

CULTURAL RELATIONS	Relationships which women involved within street level prostitution have between themselves i.e. their culture and others i.e. important others. *e.g.* *-service provider = anonymity, trust, empathy, autonomy, unreliability;* *-others/service providers = illegal, stigmatised, disempowered, private;* *-between sex workers = blame, trust* *-clients = distrust, pity, control*
DISCURSIVE CONSTRUCT	A dominant/important concept/subject raised/discussed within one or more discourses(medical, moral, legal) *e.g.* - *Pollution* - *Rights* - *Power* - *Stigma* - *Safety*
DISCURSIVE FRAMEWORK	The structure or boundary that contains the discourse; A specific set of rules/interactions (archive rules, personal discourse rules etc) that under certain conditions and when applied with authority affect the interview and the formation of concepts related to the themes, subthemes and discursive constructs in the mind of the interviewer and interviewee. Includes the supporting literature (theoretical framework) that has directed the discourse themes, the analytical framework of tools to analyse the discourse including the analysis itself.
DISCURSIVE THEME	A major research concept/'storyline' that can be followed through the research material or literature that brings together/directs disjointed concepts and discursive constructs into an underlying story/analysis. *e.g.* - *need* - *risk* - *access* - *provision*
FPSHAS	Family Planning and Sexual Health Advisory Service
GMB	A merger of multiple unions, the initials derived from General, Municipal and Boilermakers union.
HEALTH PROBLEM	When the sex worker identifies something wrong with their health, it is first identified as a problem, only if it meets specific criteria for the current conditions and existing authority will it be identified a need or risk.

NEED	Discursive theme - SW: experiences and recognises a health 'problem' which when it causes a number of lifestyle limiting effects results in the SW seeking corrective/maintenance health care provision or self-medicating, it cannot be ignored and requires action. - SP: a health 'problem' preventing 'daily activities' (e.g. work, child care) identified from knowledge and experience in biomedical and/or social models of care of SWs that requires treatment/intervention by the SP. *e.g.* *-SW: drug addiction, damaged mental health, normal STIs* *-SP: drug addiction, damaged mental health, STIs and violence* *Commentary* *The normative state for the SW is to be experiencing or recognising health problems, they do not treat this as a need. If the effects of the problem do not meet a combination of their 'in-need' criteria (e.g. reduced ability to work or function, needs medication, takes over their lives, continual, long term, limits daily lifestyle, requires some from of intervention.) then they will ignore the problem. If the problem cannot be ignored, but can be temporarily masked or managed they will self-medicate. If the effects of the problem meet a combination of their 'in-need' criteria, then they perceive that they are 'in need', this may result in self-medicating as previously indicated or seeking/accessing provision, intervention by another party, irrelevant of whether the provision is available or received. Their definition of need therefore is not dependant upon a claim or requirement for a service, but is when a combination of health problem effects seriously limit their lifestyle/daily activities requiring action.*
POLLUTION	Discursive construct - a theoretical concept used to interpret the behaviour of sex workers on and acted upon by others as though they contaminate or defile, esp. with morality - sanctity of motherhood – purity *e.g.* *Polluter morally (motherhood, family) - medically (STIs, drugs)* *Polluted medically (STIs from clients)*
POWER	Discursive construct - the ability to do or act, generally for sex workers an inability i.e. disempowerment *e.g.* *- problematic drug use, damaged mental health disempowers risk reduction and accessing health care* *- important others prevent accessing health care*
PROVISION	Discursive theme – the supply and delivery of statutory or voluntary health care services to the general public *e.g.* - *social model involving preventative, maintenance care via SHOP* - *biomedical model involving preventative and corrective care via GU*
RIGHTS	Discursive construct - the legitimate entitlement of a citizen e.g. diminished rights of access to health care. *e.g.* *- diminished rights reduced access due to bias of SP connected to soliciting and drug use* *- diminished rights due to intensity of SW problematic drug use and damaged mental health* *- diminished rights due to actions of important others* *- SW unaware of rights or think unworthy of entitlement*

RISK	Discursive theme – indicating a presence of a threat to the SW health (SW is occupational threats, SP all threats). Risk is characterised by the severity of effect and probability of occurrence, the SW only considers severity. *e.g.* - *SW violence, abnormal STIs* - *SP violence, STIs, damaged mental health, drug addiction*
RULES	Formal laws or informal social rules at a general population or peer level, a conformity or to be guided by *e.g. Responsible/irresponsible behaviours, illegality of drugs/soliciting*
SAFETY	Discursive construct - the actions to keep themselves free from the effects of occupational risks to SW health *e.g.* *- SW safer when working from violence and STIs by following responsible behaviours* *- safer within relationship with SP safer from stigma, ability to trust, anonymity and confidentiality ensured*
SEX WORKER.	A women of eighteen years and above from any social class and ethnicity, who exchanges some form of sexual service for direct (money) and/or indirect financial rewards (drugs, housing and/or consumer goods) and/or protection and the promise of love. Where this term is used in this thesis, it is implied that it is female
STIGMA	Discursive construct - a theoretical concept based on moral standards which when transgressed the person is perceived to be disgraced and be considered unworthy of attention i.e. unworthy of health care *e.g.* *- SW actual experience of stigma or the belief that they will be stigmatised if access health care* *- stigma of others due to SW drug use, damaged mental health, soliciting* *- stigma between SW (those working in parlours stigmatise those working on the street) because of irresponsible behaviours*
THEORETICAL FRAMEWORK	A set of discourses applicable to the research that have been reviewed with respect to the discursive themes to identify the discursive constructs.
WHISPER	Women Hurt in Systems of Prostitution Engaged in Revolt

APPENDIX A

SEX WORKER QUESTIONNAIRE

QUESTIONNAIRE FOR FEMALE SEX WORKERS

Zelda Leaney
University of Bath

(ALL BOLD FONT IN THE QUESTIONNAIRE TO BE READ BY INTERVIEWER TO INTERVIEWEE. INSTRUCTIONS TO INTERVIEWER IN NORMAL CASE AND ITALIC FONT. BOLD AND ITALIC FONT INDICATES TERMINOLOGY THAT MAY NEED TO BE CHANGED AS THE QUESTIONNAIRE PROGRESSES)

Interviewee (Pseudonym)	
Interviewee Reference	
Interview Location	
Interview Date	
Comment(s)	

(Introduction to questionnaire to be read by interviewer to interviewee at the beginning of the questionnaire)

This pilot questionnaire is part of a two year research project on unmet health need of *female sex workers* ***(ascertain reaction to terminology, if negative ask how the women describes herself and use this throughout the questionnaire. This may vary between individual women).*** The answers given by you will help me to design further interviews with other *female sex workers*. As I am aware that your time is limited I have designed this pilot so that it should take between 30 and 40 minutes to complete. The information that you give will remain confidential and the project that asked you to complete this questionnaire will not be identified.
I ***(the interviewer)*** will read out the questions and then write down or circle out of a list, the answer given by you. There are no wrong or right answers.

I. HEALTH NEED

To find out details on the potential risks to your health, the following section asks for details about business transactions, paying clients and non paying partners.

Ref	Question	Comment
1.	How long have you been *selling sex*? ***(ascertain the wording used by the woman to describe 'selling sex' i.e. 'prostitution', 'doing business' and use her terminology throughout the questionnaire)***	
2.	How many hours a day/night do you work?	
3.	How many day/nights a week do you work?	
4.	The risk to your health can increase with the number of clients that you see. How many clients a week do you see?	
5.	Where do you work at the moment? ***(list not to be read out but interviewer to circle the answer/s given)*** **(a) the street** **(b) Brothel** **(c) Sauna** **(d) from home** **(e) escort agency** **(f) other..** ***(interviewer to be aware that place of work could have changed over time, if this is so make a note of previous work place/s)***	
6.	What kind of *business* do you sell? ***(list not to be read out but interviewer to circle the answer/s given)*** **(a) vaginal sex** **(b) anal sex** **(c) hand relief** **(d) oral sex** **(e) sado-masochism** **(f) fantasises** **(g) domination**	

Ref	Question	Comment
	(h) other.. ***((h) to be used especially if a different terminology is used by the woman to describe the type of business transaction in the list. If a different word is used from those in the list continue to use new word throughout the questionnaire)***	
7.	Do you use any form of contraception at work? **YES NO** ***(if the answer is 'no' interviewer to move onto question no. 1.9, if the answer is 'yes' ask the woman question 1.8)***	
8.	What type of contraception do you use at work? ***(list not to be read out but interviewer to circle the answer/s given)*** **(a) condom** **(b) the pill** **(c) withdrawal method** **(d) spermicidal cream** **(e) femidom** **(f) the cap** **(g) other..** ***((g) to be used especially if a different terminology is used by the woman to describe the type of contraception in the list. If a different word is used continue to use new word throughout the questionnaire)***	
9.	Does the type of contraception that you use depend on: ***(interviewer to circle answers)*** **(a)** the type of business transaction agreed **YES NO** **(b)** the assumed respectability/look of a client **YES** **(c)** the relationship with non paying partner/partners **YES NO**	
10.	At work how do you try and protect yourself from.. ***(interviewer to read following out and write down answers)*** (a) Illness (b) violence	(a) (b) (c)

Ref	Question	Comment
	(c) rape	
11.	***(interviewer to circle answer)*** Do you have a non paying partner/partners **YES** **NO** ***If Yes,*** How long have you been with them?	
12.	The following question has four answers that will be read out to you, one of which you will need to pick. To separate paying clients with non paying partners do you use a condom for sexual intercourse with non paying partners? ***(interviewer to circle answer)*** (a) always (b) most of the time (c) some of the time (d) never	

II. ILL HEALTH

To research the possibility of unmet health need of *female sex workers*, it is important to find out the type of health problem, if any, that you had/have.

Ref	Question	Comment
1.	Could you please tell me of any health problems/illnesses that you had before *selling sex* ***(list not to be read out but interviewer to circle the answer/s given)*** **(a) HIV/AIDS** **(b) Syphilis** **(c) Gonorrhoea** **(d) Herpes** **(e) pelvic inflammatory disease** **(f) unwanted pregnancy** **(g) infertility** **(h) back ache** **(i) drug use** **(j) alcohol use** **(k) injuries from physical assault** **(l) rape** **(m) depression** **(n) anxiety** **(o) eating disorders** **(p) respiratory infections/disease** **(q) skin infections** **(r) other...** ***((r)to be used especially if a different terminology is used by the woman to describe the type of health problem in the list. If a different word is used from those in the list continue to use new word throughout the questionnaire)***	
2.	Could you please tell me of any drug/drugs that you used before *selling sex* ***(list not to be read out but interviewer to circle the answer/s given)*** **(a) cannabis** **(b) cocaine** **(c) heroin** **(d) Valium** **(e) Alcohol** **(f) Temezepam** **(g) solvents (glue/aerosols)** **(h) amphetamines (speed/whiz)** **(i) LSD**	

Ref	Question	Comment
	(j) Temgesics **(k) other…** ***((k) to be used especially if a different terminology is used by the woman to describe the type of drug used. If a different word is used continue to use new word throughout the questionnaire)***	
3.	Since *selling sex* have your health problems changed? **YES NO** ***(If 'no' move onto question 2.4. If 'YES')*** How have they changed?	
4.	Out of this list … ***(give the interviewee the list on a separate piece of paper)*** …can you identify not more than five of the most important/worrying health problems that you have had since *selling sex* Tell me ***(the interviewer)*** which is the most important, the second most important etc until you finish or reach the fifth most important) ***(the interviewer can read the list out or read specific words the appropriate item reference as identified by the interviewee then has to be written in by the interviewer)*** (a) HIV/AIDS (b) Syphilis (c) Gonorrhoea (d) Herpes (e) pelvic inflammatory disease (f) unwanted pregnancy/abortion (g) infertility (h) back ache (i) drug use (j) alcohol use (k) physical injury (l) rape (m) depression (n) anxiety (o) eating disorders (p) respiratory infections/disease (q) skin infections **(r)** other (please explain)… ***((r) to be used especially if a different terminology is used by the interviewee to describe important/worrying health problems. If a different word is used continue to use new word throughout the questionnaire)***	
5.	Do you have routine health checks? **YES NO** *(If 'yes' move onto question 2.6. If 'No'..).* Why do you not have routine health checks?	

Ref	Question	Comment
	(interviewer to circle answers given by interviewee) **(a) nothing wrong with me** **(b) nothing seriously wrong with me** **(c) lack of time** **(d) no where to go** (e) **other people stop me**	
6.	Have you been ill since *selling sex?* **YES NO** ***(If 'no' move on question 2.8. If 'yes'..)*** Have you seen a GP/nurse/doctor/project worker? **YES NO** ***(if 'yes' go onto question 2.7, if 'no' go onto question 2.9)***	
7.	How long did you have the symptoms before you went to see a GP / nurse / doctor / project worker?	
8.	Since selling sex have you received any treatment for a health problem? **YES NO** If you can remember what was the treatment? ***(interviewer to write down answer)***	
9.	How long would you leave symptoms before you would go and see a GP / nurse / doctor / project worker?	
10.	Out of this list ... ***(give the interviewee the list)*** ...what would make you go and see a GP / nurse / doctor / project worker Tell me ***(the interviewer)*** and I will circle the answer/s) ***(the interviewer can read the list out or read specific words)*** (a) fear that you have an infection (b) fear that your partner/client has an infection (c) fear that you can pass on an infection (d) pain (e) other physical symptoms (f) mental problems (g) cut down/come off drugs (h) change in relationship (i) pressure from a friend/family (j) other (please explain).... ***(no. 10 to be used especially if a different terminology is used by the interviewee to describe physical/psychological symptoms. If a different word is used continue to use new word throughout the questionnaire)***	

III. HEALTH CARE PROVISION

This section of the questionnaire looks at the type of health care provision that is available in the city, to see if there are services to deal with the health problems that you have identified in the previous section.

Ref	Question	Comment
1.	What health care do you know of that is available in the city? ***(list not to be read out but interviewer to circle the answer/s given)*** **(a) GU clinic (sexual health)** **(b) drug advice** **(c) drug detox / methadone prescription** **(d) drug outreach** **(e) sexual health outreach** **(f) GP** **(g) A&E** **(h) drug drop in** **(i) sexual health drop in** **(j) general drop in** **(k) other..** ***((k) to be used especially if a different terminology is used by the interviewee to describe health care. If a different word is used continue to use new word throughout the questionnaire)***	
2.	If you were ill where would you go? ***(list not to be read out but interviewer to circle the answer/s given)*** **(a) GU clinic (sexual health)** **(b) drug advice** **(c) drug detox / methadone prescription** **(d) drug outreach** **(e) sexual health outreach** **(f) GP** **(g) A&E** **(h) drug drop in** **(i) sexual health drop in** **(j) general drop in** **(k) don't bother** **(l) other...**	

Ref	Question	Comment
3.	Of the place/s that you would go to if you were ill how did you hear about it/them? ***(list not to be read out but interviewer to circle the answer/s given)*** **(a) friends/family** **(b) outreach workers** **(c) leaflets/cards** **(d) GP** **(e) Police** **(f) other...** ***((f) to be used especially if a different terminology is used by the interviewee to describe who informed them of the health care. If a different word is used continue to use new word throughout the questionnaire)***	
4.	If you were unwell would you prefer to see.. ***(read options out to interviewee and circle answer)*** (a) female staff (b) male staff (c) doesn't matter	
5.	Is the place that you would go to if/when you are unwell.. **(a)** for everyone (fe/male, non/*sex worker*) **YES NO** **(b)** for women only? **YES NO** (c) for female sex workers only? **YES NO** ***(If 'yes' to question 3.5(a) go onto question 3.7)***	
6.	In the city is there any health care/project solely for female sex workers? **YES NO** ***(If 'no' go onto question 3.8)***	
7.	What health care does the service provide? ***(list not to be read out but interviewer to circle the answer/s given)*** **(a) sexual health (condoms, advice)** **(b) drugs (clean needles, advice)** **(c) blood/saliva tests** **(d) smears/vaginal swabs** **(e) counselling** **(f) other...**	

Ref	Question	Comment
8.	Of the places that you would go to when you are unwell do you know how many are voluntary and how many are NHS/social services? ***(list not to be read out but interviewer to circle the answer/s given)*** **(a) voluntary** **(b) NHS/Social Services** **(c) a combination of voluntary and NHS/Social Service** **(d) don't know**	
9.	If you had a choice what kind of project would you like to go to when you are unwell or worried?	

IV. ACCESS TO HEALTH CARE

To further explain differences in health and disadvantages when going to see a GP/nurse or going to hospital/clinic this section of the questionnaire looks at how easy health care is to use.

Ref	Question	Comment
1.	Out of the places that you would go to when you are ill, are they easy to use? **(if 'yes' go onto question 4.3, if no ask question 4.2)**	
2.	Why are they not easy to use? ***(list not to be read out but interviewer to circle the answer/s given)*** **(a) location of health care** **(b) opening times** **(c) conditions attached to provision of health care** **(d) inappropriate advice given by the health provider** **(e) lack of child care** **(f) waiting list** **(g) need to be referred by another project / agency / GP** **(h) other..**	
3.	Out of this list .... ***(give the interviewee the list)*** .... can you identify not more than five important reasons why you would use a particular clinic/project or see a certain nurse/GP/doctor Tell me ***(the interviewer)*** which is the most important, the second most important etc until you finish or reach the fifth most important ***(the interviewer can read the list out or read specific words the appropriate number as identified by the interviewee then has to be written in the box by the interviewer)*** (a) they have what I need (b) no appointment is necessary (c) less possibility of rejection (d) independent from NHS/Social Services (e) less stigmatising (f) more confidential	

Ref	Question	Comment
	(g) easy access (h) voluntary (i) offers more than sexual health and advice (j) not just for female sex workers (k) only for female sex workers (l) the staff are friendly **(m)** other...	
4.	Health problems and inadequate provision of, and access to, health care can vary depending on a woman's age and ethnicity. To further understand any disadvantage in relation to health care and the possible reasons for unmet health need, it would be very helpful if you could tell me your age and your ethnicity. AGE **(a) 15-18** **(b) 19-22** **(c) 23-27** **(d) 28-31** **(e) 32-35** **(f) 36-39** **(g) 40 and over** ETHNICITY (a) **Afro Caribbean** (b) **Asian** (c) **White (UK)** (d) **White (Eastern European)** (e) **other...**	

Thank you for your time

APPENDIX B

GRAPHICAL ANALYSES

This appendix includes useful diagrammatic analyses used to bring together the multitude of discursive constructs, themes and discourses to help relate the research themes to published discourse.

Figure 1 identifies the discursive framework of the research. The research is based on four main themes; two primary; need and risk, and two secondary; provision and access. These themes have been used to review the prominent literature identified within dominant discourses. Within these discourses pertinent discursive constructs are identified which in most cases span discourses. Below them is shown the investigative research. The themes drove the interview questions. The interviews were analysed using thematic analysis, identifying sub-themes that related to these main research themes. Finally the sub-themes are related back to the original discursive constructs, via the main themes.

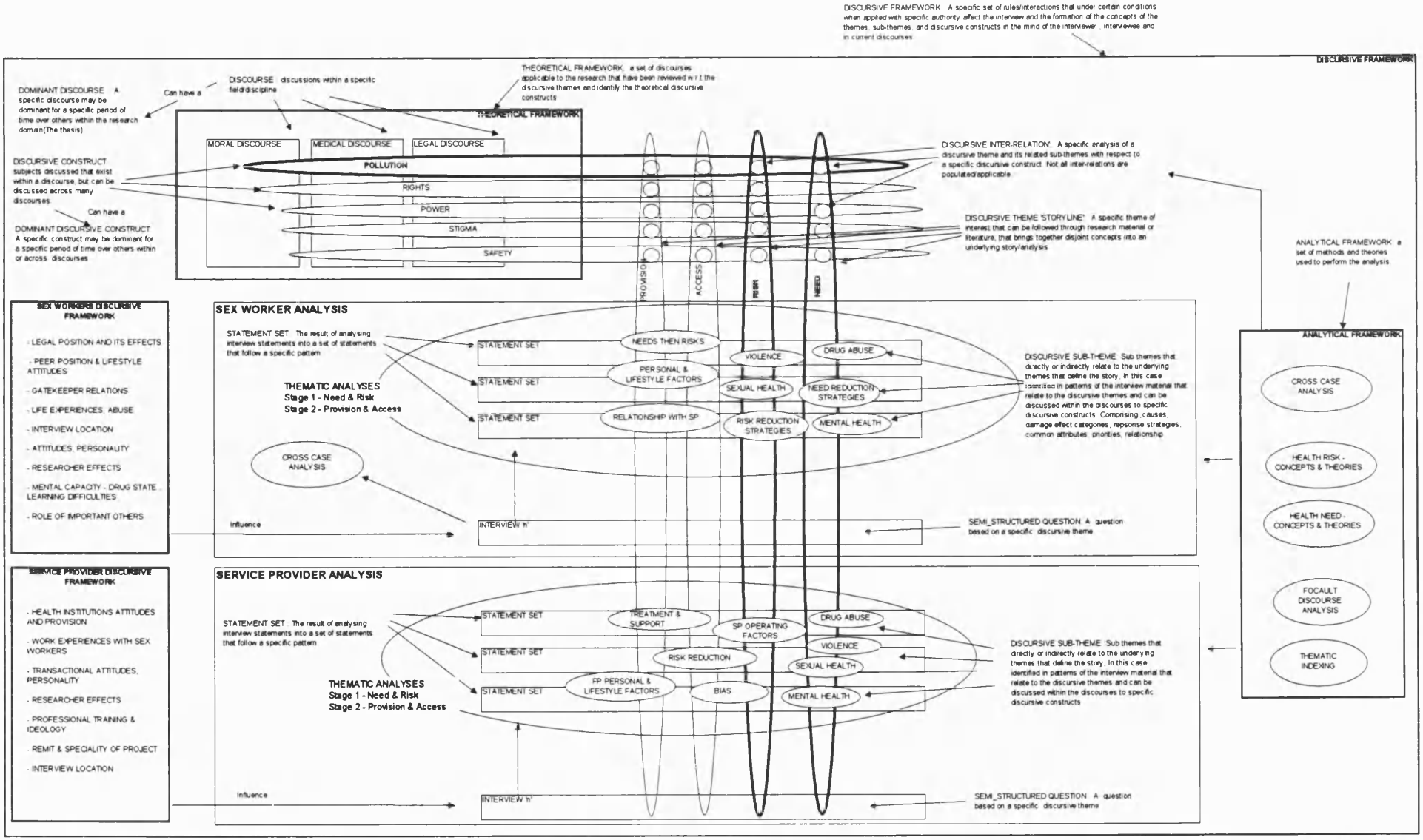

Figure 1 : Relationship between Research Themes and Discourses

APPENDIX C

INTERVIEWEE PROFILES

This appendix provides profiles of the interviewees who took part in this research.

I. A Profile Of Each Sex Worker

Abby was 21 at the time of the interview. She had stopped working 3 to 4 months before the interview took place and had moved out of the working and drug using community. The gatekeeper brought her in to the sexual health outreach project for the interview. She had been in Children's Homes, foster care and secure units until the age of 13 when she had run away from foster care. Abby recounted meeting a woman in a park who offered her somewhere to stay but introduced her to 'crack'. At the time she had no idea what the drug was. The woman 'made' her have sex with the drug dealer to pay for the drugs and in the end Abby ended up working from the streets. She had always worked from the streets and in client's cars. She had been sexually attacked once and beaten by an ex pimp. Abby was the only sex worker who mentioned having a pimp. She had worked solely for money to buy heroin, speed and 'crack'. Abby identified drug usage as a health need, she was on prescribed methadone at the time of the interview. When she had been working risks to her health were pregnancy, catching a sexually transmitted infection and violence.

Fiona completed the questionnaire and was also interviewed at the sexual health outreach project after being dropped off by the gatekeeper. She had not wanted to be interviewed at the parlour where she worked. Fiona was 38 and had been working in private premises for 10 years. At the time of the interview she was seeing approximately five clients a week. She had been married twice and had three children. Her first husband and one of her ex partners had been alcoholics and violent. She had worked for a little while in care homes. Fiona claimed not to have any health needs caused by working although she mentioned depression and stated she had never taken drugs. She identified risks to her health as HIV/AIDS, syphilis, gonorrhoea, herpes and chlamydia.

Ebony took part in both the questionnaire and the interview. On both occasions she came in to the sexual health outreach project by herself. Since the age of four she had a history of psychological problems. She was 21 at the time of the interview and had started working from the streets after being raped at the age of 17. Being raped had dramatically increased her drug use and prostitution was the only way she saw to finance her increasing and varied drug habit. She had also been sexually assaulted when working. Ebony had not worked for the last two years but had gone back to the streets a week before completing the questionnaire and had been working for four weeks when I interviewed her. She had returned to work as she needed to fund her drug habit. She had lost her prescription for substitute medication after leaving a drug rehabilitation programme early. She was using 'smack' and ecstasy at the time of the interview but had completed detoxification programmes for heroin, methadone, Valium, amphetamine and alcohol dependency in the past. Previously Ebony had contact with 25 to 35 clients per week but at the time of the interview she was contacting 4 to 5 regular clients when she needed the money and going to the client's homes. Ebony identified rape as a risk to her health despite seeing only a few regular clients and damaged mental health as a need. The interview was stopped when she became upset about her new boyfriend.

Dee was interviewed at her flat with the gatekeeper in attendance. She had also agreed to do the questionnaire but was not available. Dee was 30 and had currently been working for 4 years, but she had worked in 1985 for about three years. She was 14 years of age when she first started working. Until March 2001 Dee had always worked from the streets but since renting her present flat she had worked from home. She was seeing approximately fifteen regular clients a week, clients filtered from the clients that she had seen on the streets. She was a non-drug user although had taken speed on a couple of occasions. Dee believed risks to her health had reduced since working from home, although sexually transmitted infections were still identified as health risks. For Dee they all held the same fear from AIDS to chlamydia. Dee claimed health needs she had were depression, thrush and cystitis all she believed caused by work.

Babs was interviewed at the sexual health outreach project after being bought in by the gatekeeper. At Babs' request the gatekeeper stayed with her during the interview. Babs was 49 and had worked for twenty years, always worked in 'Old Port' and always from the street. Babs had been married and had five children all of whom had been taken into local authority care. She had not known what had happened to her children until the gatekeeper

had traced them for her. Babs had recently met one of her sons, which she said had gone well and had put her mind at rest as she now knew her children were safe. She reported that she had not been working for a while although she had still been going to the red light district and when possible stealing from the clients. She had been a heavy drug user in the past and was still using some speed and alcohol recreationally. Babs identified her health needs as mental health and was a diagnosed paranoid schizophrenic. She felt a health risk when she had been working was violence as she had been violently and sexually attacked twice in the year and a half before the interview. When she had been raped the rapist did not wear a condom. The interview was stopped, as Babs was unable to concentrate and was becoming very tired.

Summer was picked up from her home by the gatekeeper and driven to the parlour where the interview took place with the gatekeeper in attendance. She was 30 and had worked periodically for seven years. She had always worked in parlours never from the street and occasionally in a different town as a favour for a friend. Summer saw upwards of three clients a week however, in the day before the interview she had seen six clients and reported earning more in one day than she had the whole of the previous week. She smoked cannabis occasionally but admitted to having a heavy alcohol habit. Summer had been married once and had two children who both lived with her. Both of the children knew she worked at the parlour but believed she was the receptionist and did not sell sex. She had been sexually abused in the past. She could not identify any risks to her health but did attribute thrush and depression to working.

Diane made her own way to the sexual health outreach project to be interviewed. She was 29 and had been working mainly from the street for four years. She occasionally worked from her bedsit when clients phoned her who did not like going to the street. Diane had also worked for a couple of weeks in a licensed massage parlour. She saw approximately thirty clients a week of whom approximately 80% were regulars. She claimed to be a non-drug user. Diane identified AIDS and sexually transmitted infections as risks to her health. She had been beaten up when a man stole £20, she had been kept prisoner in a clients house for several hours where he had slapped her repeatedly across the face and she had been anally raped by another man. She identified a health need as depression.

Kitty was 39 and had been working for three months in the parlour where the interview took place. In addition to seeing approximately twenty five regular clients a month she saw

the clients who walked in off the street. She grew up in a Children's Home but ran away from it with a girlfriend when she was 14 or 15. The girlfriend worked on the streets to earn money but Kitty claimed she did not have the courage to do this. Her previous heterosexual relationships had all been violent due to the partners drinking. She had four children the girls lived with her but the boys did not. Kitty had been in her present relationship for eleven years. Her partner who had a job knew that she was learning to become a mistress but did not know that due to pressure from the managers of the parlour, she had also agreed to do relaxation as well. Connected with the relaxation Kitty identified AIDS and other sexually transmitted infections as a risk to her health. Kitty was a registered anorexic. She claimed that her health had improved due to working as she was smoking less cannabis, was eating more food and had put on a stone in weight and felt really good after practising domination.

Lou agreed to be interviewed between clients in a flat in the red light district with the gatekeeper in attendance. She was 37 and had been working for nineteen years. She had always worked from the street, except for a twelve month period when she advertised in a sex shop. For short periods of time Lou had also worked in another city. At the time of the interview she saw approximately twenty clients a week, 90% of whom were regulars. She was a non-drug user although she had a previous heroin dependency that had lasted between the ages of eighteen to twenty one. She mentioned briefly about being sexually abused by a male relative. Lou had been in a relationship virtually the length of time that she had been working. She described it as a stable relationship for the last seven years and she had one son and one daughter both of whom lived with her. Lou did not identify any risks to her health, she had never been sexually assaulted but health needs associated with working were depression, thrush and cystitis.

Maisie was 20 and had been working from the street for five years. Initially, due to her age, she worked periodically but had worked regularly since the age of 16. I interviewed her at the sexual health outreach project after the gatekeeper bought her in. She had worked for a little while doing escort work but had returned to the street, as with escort work she was unable to turn clients away if she did not like the look of them. She mentioned very briefly that she had been abused as a child by a male relative and had been in and out of psychiatric care since the age of five. Maisie reported having a very large heroin habit, which she had been able to cut down to twice a week, she smoked cannabis continually, took prescribed Prozac and bought methadone from the street. Six months before the interview she had been working seven days a week but since reducing her heroin usage

she worked between two and three days a week seeing approximately ten clients during that time. Maisie had moved out of the drug and working community. The greatest risk identified was being attacked as she had been physically assaulted by one client and threatened with a Stanley knife by another. Working on the street made her depression worse.

Nikki at the time of the interview was 24 and had worked for five years up until eighteen months before the interview. She had seen between two and six clients a night working four or five nights a week. I interviewed her at the sexual health outreach project. She had come in with the gatekeeper after they had taken Nikki to see her psychiatrist about proposed sex change surgery. She had worked from the street in her first year and then from home, with regulars, with the occasional 'social visit' to the street. She claimed to have used every drug that was available on the street but at the time of the interview was using mainly ecstasy and alcohol. Nikki was engaged but had recently found her male 'fiancé' in bed with her best male friend. As a consequence Nikki and her fiancé were homeless as they had been staying with Nikki's friend. Nikki was sleeping on friends' floors and had moved again on the day of the interview. When she had been working she identified violence as a risk to her health as she had been physically attacked once, a client had hit her across her face. Mental health was her most pressing need.

Comment: Although Nikki does not strictly meet the thesis definition of a female sex worker she has undergone gender re-assignment from an early age. She thinks, acts and dresses as a woman and as such Nikki is considered as a woman in this research.

Polly was interviewed in her home, after I had been taken there by the gatekeeper who was present at the interview as was Polly's husband. She was 38 and had been working for two years as a dominatrix. Polly had started working in parlours but had been working independently in rented rooms in 'Old Port'. She was at the time of the interview looking for new premises. She was a non-drug user, did not smoke and she claimed to only drink alcohol occasionally. Polly had five children, four boys and a girl, all of who lived with her and her husband. She had never been attacked but saw this as a possible risk to her health, although a minimum risk, as her husband was always close by and the majority of her clients were regulars.

Queenie was bought into the sexual health outreach project by the gatekeeper for the interview. Queenie worked from the streets taking clients back to her flat she shared with a male friend. There was always someone in another room in the flat in case the client became violent. She was 26 at the time of the interview and worked periodically, she had been working for the last four months but had started on the streets at the age of 15. Queenie had been in a violent long term relationship from which she had two boys, both of whom had been adopted due in part to her drug usage. She was taking amphetamines and 'smack' but trying to reduce her 'smack' habit with the ultimate aim of stopping its use completely, this was identified as a health need. Queenie was doing this without a prescription for substitute medication. Before reducing her 'smack' habit she had worked seven days a week seeing at least six clients a night. At the time of the interview she was seeing three or four clients a night, when she needed the money. Being attacked was a risk to Queenie's health, she had been attacked when she was 15 but could not talk about it. The interview was stopped as Queenie became very upset talking about how frightening working on the street could be.

Liz had been working periodically since the age of 16 predominately from the street. She initially saw one client on a Saturday night to earn money to buy alcohol. Before friends introduced her to heroin Liz had completed National Vocational Qualifications levels I, 2 and 3 in nursing. She had been in a relationship between the ages of thirteen to twenty two and her eight year old son lived with her ex-partner. She had known her present partner for seven years. She was 25 at the time of the interview and used both heroin and Valium. Liz was interviewed at the sexual health outreach project. Due to being sexually assaulted on the street eighteen months before the interview Liz had only been to the red light district once in this time. For a short time straight after the attack she had worked in a massage parlour but left the parlour as she did not like the owners taking a percentage of what she earned. Liz had been seeing three regulars a week at home. When she had been working on the street she had worked seven nights a week seeing approximately five clients each night. Liz identified being attacked as a risk to her health and drugs as a health need.

Katrina was interviewed at the parlour where she was manageress. She had worked periodically for five years, always in private premises and for four months in 'Old Port'. When asked how many clients she saw in a week she gave a total of 7699 clients seen in her career up to the time of the interview. She was 27 and although she had been dependent on 'speed' for two years when she had first started working at the time of the

interview she described herself as a recreational drug user. Katrina had been very badly beaten by an ex boyfriend, the boyfriend who had introduced her to 'speed'. As a result of not being able to work she had lost her job and her accommodation and she claimed she had been unable to get social security help. This she identified as a turning point in her life and the point when she started sex work. For Katrina a risk that working posed to her health was 'getting out of shape' and believed working did not cause any health needs.

Cath worked in the same parlour as Katrina. This is where she was interviewed and where she had worked for over a year. Cath had worked periodically for two years. Previously she had worked in a licensed massage parlour offering hand relief. Cath saw approximately ten clients a week although the week before the interview she had not seen anyone. She was 21 at the time of the interview and had started working while studying for her 'A' levels. Her partner of just over two years was employed. She claimed that from the age of 13 she had occasionally smoked 'dope'; she took 'speed' recreationally and rarely drunk alcohol. Although Cath could not identify any major risks to her health possible risks were infection caught as a result of a condom splitting or catching 'crabs' and no identification of health needs.

May was 37 at the time of the interview. She had worked periodically for seventeen years throughout England, Scotland and in the Middle East. She had been working in the parlour in Old Port for six weeks helping Katrina, who was a personal friend. May worked from home, parlours and other women's premises. She had never worked from the street. She claimed to be a recreational drug user using 'speed' on and off for years and occasionally drinking alcohol. May's older sister also worked and they had worked together. May could not identify any heath risks as she claimed she did not to take risks, this was despite being raped at knifepoint and an attempted robbery, both taking place in private premises in London. Health needs made worse by working were thrush and cystitis.

Tracey was interviewed at the sexual health outreach project after being bought in by the gatekeeper. She started to work at the age of 15 after running away from home at the age of 14, to get away from her dad. She was 30 at the time of the interview and had worked for a total of eight years. She had stopped for two and a half years to have a baby. Her eleven year old son lived with her mother in another city. Tracey had always worked from the street but after picking clients up tried to take them back to her flat. She worked seven days a week and saw approximately two clients a night. Tracey had used heroin for the last eight

years and claimed to occasionally use 'speed', drugs were identified as a health need. For Tracey a risk to her health was violence. She had been raped without a condom approximately ten years before the interview and about a year and a half ago she had been badly beaten and sexually assaulted. A few clients had also become violent slapping and kicking her. Tracey stopped the interview as she wanted to get home.

Belinda was interviewed at the sexual health outreach project. She had started to work when she was approximately 28 and she was 33 at the time of the interview. Belinda had stopped working approximately four months before the interview. She had worked from the street every night, taking the clients back to her flat. Her father had sexually abused her. Belinda had two girls both of whom had been adopted and she had been with her present partner for four years. She started using heroin at the age of eighteen but had not used it for seven years, she was on a methadone prescription. Since she had stopped working the amount of speed she took had reduced. When Belinda had been working she believed violence was a health risk, she recounted being raped about five years before the interview and another client had tried to pull her into a lane. Mental illness was identified, as a health need. The interview was stopped as Belinda was falling asleep.

Angela took part in the interview at the sexual health outreach project. She had been working from the streets for approximately seven years and at the time of the interview she was 28. Angela worked for four nights a week for three to four hours and within this time saw approximately twelve clients a week. Once she picked the client up she tried to take them back to the flat where her fiancé would be sitting in another room. She smoked cannabis daily. Angela identified the other sex workers as a potential risk to her health due to their bitchiness and stealing. Angela had been attacked twice by clients neither of the attacks were sexual. She blamed both attacks on men seeking revenge for money being stolen from them by other sex workers. Angela identified cystitis and thrush as a health need.

Gillian was 27 at the time of the interview and had been working periodically since the age of 21. Working was something that she did when she was desperate for money. When she did work it was usually for two nights a week for two hours each night within which time she would see approximately ten clients. She had always worked from the street. She reported being raped by her father as the incident that started her heroin usage. She claimed not to be using heroin when she first started working. Gillian also smoked cannabis daily and

when she was working used Valium and amphetamines. Being raped again was the risk to her health that she feared the most, identifying drug use and mental illness as health needs.

Table 2 is an output of the cross case analysis and provides the salient characteristics of each sex worker.

	ABBY	FIONA	EBONY	DEE
AGE	21	38	21	30
WORKING STATUS	Out of work	In work	4 weeks after period away of 2 years	4years after a break
WORKING LOCATION	Streets & Cars	Parlour	Street & clients homes	Street but now her flat
EXPERIENCE	8 years	10 years	4 years	7years
CLIENTS	Not Specified	5 per week	25-30 a week but now 4-5 when money required	15 regular clients a week
WORK - SEXUAL ATTACKS	1	0	1 Rape, 1 Sexual Assault	0
WORK - VIOLENCE ATTACKS	1	0	0	0
PROSTITUTION REASON	Drug addiction	Previous partners being alcoholics, money	Started after rape, finance drug habit	Money & lack of home life
AGE WHEN STARTED	13	28	17	14
FAMILY/RELATIONSHIP STATUS	No Partner	Married Twice	New Partner	Partner
DRUGS	Crack, heroin, speed	None	Heroin & ecstasy	Speed a couple of times
PRESCRIPTION DRUGS	Methadone, diazepam	None	Loss of prescription	Contraception
CHILDHOOD	Care Homes, Secure Units, foster homes	Not Specified	Psychological problems from age 4	Not Specified
MEDICAL HISTORY	Drug addiction, mental health problems	Depression	Psychological problems, drug rehab, completed detoxification programmes for heroin, methadone, valium, amphetamine and alcohol dependency in the past	STI treatment (herpes)
WORK - HEALTH NEED	Drug usage	None	Mental Health, Drug Usage	Depression, thrush and cystitis
WORK - HEALTH RISKS	Pregnancy, STI, violence	HIV/AIDS, syphilis, gonorrhoea, herpes and chlamydia	Rape	STIs
INTERVIEW LOCATION	Brought in to Outreach project	Brought in to Outreach project	Came in to Outreach project	Flat
OTHER ATTENDANCE AT INTERVIEW	No	Questionnaire: Gatekeeper at her request	No	Gatekeeper
QUESTIONNAIRE	No	Yes	Yes	Yes but not available
INTERVIEW COMPLETED	Yes	Yes	No became upset talking about Partner	Yes

Table 2 Sex Worker Salient Characteristics

	BABS	SUMMER	DIANE	KITTY
AGE	49	30	29	39
WORKING STATUS	Not working recently, but stealing from clients	In work	In work	3 months in parlour
WORKING LOCATION	Street, city	Parlour	Street, sometimes at home	Parlour
EXPERIENCE	20years	Periodically for 7 years	4 years	3 months
CLIENTS	10 regulars a week	3-6 clients a week	30 clients a week 80% regulars	25regulars + a month
WORK - SEXUAL ATTACKS	1 Rape, 1 Sexual Attack	0	1 Rape	0
WORK - VIOLENCE ATTACKS	2	0	2	No whilst working but in relationships
PROSTITUTION REASON	Not Specified	Not Specified	Not Specified	To practise domination
AGE WHEN STARTED	29	23	25	39
FAMILY/RELATIONSHIP STATUS	Married but separated	Married but separated	None	Heterosexual relationships were violent, current relationship 11 years
DRUGS	Speed and alcohol	Cannabis and alcohol	None	Cannabis
PRESCRIPTION DRUGS	Sleeping Tablets	Anti-Depressants	None	None
CHILDHOOD	Schizophrenic medication	Sexually abused	Not Specified	Home ran away 14-15
MEDICAL HISTORY	Heavy drug user in the past, mental health needs, paranoid schizophrenic	Thrush, depression	Depression	Anorexia
WORK - HEALTH NEED	Mental Health	Thrush, depression	Mental Health	Mental Health
WORK - HEALTH RISKS	Violence	None	AIDS & STIs	AIDS & STIs
INTERVIEW LOCATION	Brought in to Outreach project	At Parlour	Came in to Outreach project	Parlour
OTHER ATTENDANCE AT INTERVIEW	Gatekeeper at her request	Gatekeeper	No	No
QUESTIONNAIRE	No	No	No	No
INTERVIEW COMPLETED	No, Babs couldn't concentrate	Yes	Yes	Yes

	LOU	MAISIE	NIKKI	POLLY
AGE	37	20	24	38
WORKING STATUS	In work	In work	Not worked in last 18 months	2 years as dominatrix
WORKING LOCATION	Street, except 12 months in a sex shop	Street	Street 5 years, now from home	Rooms but previously parlours
EXPERIENCE	19 years	5 years	5 years	2 years
CLIENTS	20 clients a week 90% regulars	10 clients a week	8-30 a week	10-15 a week
WORK - SEXUAL ATTACKS	0	0	0	0
WORK - VIOLENCE ATTACKS	0	2	1	0
PROSTITUTION REASON	Drugs	Drugs	Enjoy Sex	Enjoy Domination
AGE WHEN STARTED	18	15	17	36
FAMILY/RELATIONSHIP STATUS	19 year relationship, stable for 7 years	No Partner	Engaged but possible separation	Married
DRUGS	None	Very large heroin habit, twice a week, smoked cannabis continually, took methadone from the street	Had used all but now ecstasy & alcohol	None, alcohol
PRESCRIPTION DRUGS	Contraception	Prozac	Hormone therapy	None
CHILDHOOD	Sexually abused by relative	Abused by relative	Gender re-alignment	Not Specified
MEDICAL HISTORY	Previous heroin dependency 18-21	Psychiatric care since the age of five	Psychiatric support and sex change support	No Issues
WORK - HEALTH NEED	Depression, thrush and cystitis.	Depression, drugs	Mental Health	None
WORK - HEALTH RISKS	None	Violence	Violence	Violence
INTERVIEW LOCATION	Working Flat	Brought in to Outreach project	Brought in to Outreach project	Her home
OTHER ATTENDANCE AT INTERVIEW	Gatekeeper	No	No	Gatekeeper & Husband
QUESTIONNAIRE	No	No	No	No
INTERVIEW COMPLETED	Yes	Yes	Yes	Yes

	QUEENIE	LIZ	KATRINA	CATH
AGE	26	25	27	21
WORKING STATUS	Working for last 4 months	Only once in last 18 months	In work	At parlour for last year
WORKING LOCATION	Streets and flat	Street, now mainly at home	Parlour, private	Parlour
EXPERIENCE	6 years	Periodically since 16, possible 9 years	Periodically 5 years, 7699 clients	Periodically for 2 years
CLIENTS	15-30 clients a week	On street up to 35 a week now 3 regulars a week at home	Estimate 30 per week	10 per week
WORK - SEXUAL ATTACKS	Possibly 1	1	0	0
WORK - VIOLENCE ATTACKS	Possibly 1	0	0	0
PROSTITUTION REASON	Money and already associating with sex workers	To buy alcohol	Loss of job	Enjoyed Sex and needed money
AGE WHEN STARTED	15	16	22	18
FAMILY/RELATIONSHIP STATUS	Violent long term relationship	Previous 9 year relationship, current 7 year relationship	Badly beaten by previous boyfriend	Partner of 2 years employed
DRUGS	Amphetamines and 'smack'	Heroin and valium	Speed dependency in the past	Speed, cannabis
PRESCRIPTION DRUGS	None	None	Contraception	None
CHILDHOOD	Violent attack at early age	Not Specified	None	None
MEDICAL HISTORY	Not Specified	Addiction – Detox	Speed addiction	No Issues
WORK - HEALTH NEED	Drugs	Drugs	None	None
WORK - HEALTH RISKS	Violence	Violence, Pregnancy	Getting out of shape	STIs
INTERVIEW LOCATION	Brought in to Outreach project	Outreach project	Parlour	Parlour
OTHER ATTENDANCE AT INTERVIEW	No	No	No	No
QUESTIONNAIRE	No	No	No	No
INTERVIEW COMPLETED	No. Halted interviewee became upset	Yes	Yes	Yes

	MAY	TRACEY	BELINDA	ANGELA	GILLIAN
AGE	37	30	33	28	27
WORKING STATUS	Six weeks at parlour	In work, 2.5 year break for baby	Not working for 4 months	Working	In work
WORKING LOCATION	Parlour, homes	Streets and flat	Street and flat	Streets & Flat	Street
EXPERIENCE	17 years	8 years	Possibly 5 years	7 years	Periodically for 6 years
CLIENTS	Not Specified	14 clients a week	Not Specified	12 clients a week	10 clients a week
WORK - SEXUAL ATTACKS	1 Rape	1 Rape, 1 Sexual Assault	1 Rape	0	0
WORK - VIOLENCE ATTACKS	1 Robbery	1 beaten, 2/3 minor violence	1 Attempted assault	2	0
PROSTITUTION REASON	Not Specified	Money, Poverty	Not Specified	Not Specified	When desperate for money
AGE WHEN STARTED	20	15	28	21	21
FAMILY/RELATIONSHIP STATUS	Partner	No Partner	4 years with current partner	Fiancé	No Partner
DRUGS	Speed, alcohol	Heroin and speed	Heroin but not used for seven years, speed	Cannabis daily	Heroin, cannabis daily, valium and amphetamines
PRESCRIPTION DRUGS	None	None	Methadone	None	None
CHILDHOOD	None	Ran away from her father at 14	Sexually abused by father	Not Specified	Raped by her father
MEDICAL HISTORY	No Issues	Addiction	Anorexia, Addiction	Kidney Problems, Drug Addiction	None Specified
WORK - HEALTH NEED	Thrush and cystitis	Drugs	Mental Health, Drugs	Cystitis & Thrush	Drugs & Mental Health
WORK - HEALTH RISKS	None	Violence	Violence	Other women due to stealing and bitchiness	Rape
INTERVIEW LOCATION	Parlour	Brought in to Outreach project	Outreach project	Outreach project	Outreach project
OTHER ATTENDANCE AT INTERVIEW	No	No	No	No	No
QUESTIONNAIRE	No	No	No	No	Yes
INTERVIEW COMPLETED	Yes	No, she wanted to get home	No, she was falling asleep	Yes	No (Not Interviewed)

II. A Profile Of Each Service Provider

The following provides a brief overview of the service providers and the interviewees.

(i) Statutory Drug Project

The project is part of the mental health directorate and primary care trust. It provides drug care to the local community covering treatments such as substitute medication and psychiatric counselling. Two members of staff were interviewed from this project. The first interviewee was a consultant psychiatrist specialising in substance misuse. She is medical lead for the substance misuse services, assessing or reviewing clients with either complex drug misuse or psychiatric problems. Out of the women seen by the project she believes approx 30-50% are sex workers. The second interviewee is a locum drugs worker, a social worker, who has worked at the project for eight years managing a client case load for drug treatment and testing, risk assessments of clients.

(ii) Statutory Drug Unit

This service is situated in a NHS hospital, on an acute psychiatric admission ward and provides psychiatric care, drug reduction and stabilisation. Its funding and thus services has dramatically reduced from over a year ago, providing only four beds often taken by psychiatric cases. The interviewee was the senior drug adviser having worked on the unit for two years with five other drug workers. He believed 90% of planned female admissions are sex workers or have sold sex at some point.

(iii) HIV Advice Project

This is a voluntary project formed in 1991 funded on a three year contract by the health authority and council with six staff and a few volunteers. The project has an informal attitude with open access mainly by self-referral. The aim of the project is to provide information on welfare rights, counselling, advocacy and bereavement support for people with HIV and Hepatitis C. The interviewee is a support worker from a community work based background with one years experience in the post. The project had contact with few sex workers using their service.

(iv) Genito-Urinary Clinic

The clinic is part of the NHS obstetric and gynaecology directorate based outside the city centre. It provides open access for basic genital examinations, biopsies, local anaesthetic procedures, STI treatment and vaccinations. No record is kept of sex workers attending the clinic. The first interviewee is a Senior Health Adviser who was treated many sex workers at the clinic and staffed an outreach sexual health bus for sex workers for six years. The second interviewee is also a Health Adviser but in addition provides Desensitisation and Reprocessing (D&R) treatment at the clinic treating sex workers for sexual abuse.

(v) Family Planning and Sexual Health Advisory Service

The clinic is one of thirteen in 'Old Port' funded by the Primary Care Trust staffed by professionals (e.g. Doctors, Nurses, Managers). It provides, advice on all methods of contraception, sexual health advice, cytology, pregnancy testing and issue contraception. The interviewee is a manager for the service a Registered General Nurse and as with all nurses within the service holds the additional ENB in Family Planning. The service was unaware of the number of contacts by sex workers.

(vi) Police

The 'Old Port' police force does not have a vice squad presumed to be a result of funding and vice is not perceived as a big problem in the area. Prostitution is policed by the ward team. The police force interviewee is a WPC performing the job of Problem Solver within which is the role of prostitution liaison officer. The approach is multi agency, re-directing issues reported to the police that is not within their remit. She had been in the role for over two years. She knew of over fifty street sex workers, twenty five had been convicted of soliciting.

(vii) Sexual Health Outreach Project

The project is a voluntary organisation started in 1997 funded by the health authority and Single Regeneration Budget located in the drug and alcohol agency building. It provides information on safety, advocacy, support, needle exchange prioritising in sexual health and drug work for sex workers at the building and via outreach work. Two members of staff were interviewed. The first interviewee (A) is NVQ qualified, and has worked in the statutory and voluntary sector within sexual health for twenty years. Worked primary with street sex workers recently extended to include sex workers working privately. The second interviewee (B) has worked in the voluntary sector for over twenty years with no qualifications but has

experience working with children and drug misuse. She has been working within sexual health and with sex workers for last four years. She predominately had contact with street working sex workers.